An Exploration Of The Use Of Eye Movement Desensitization And Reprocessing (EMDR) Techniques Within A Solution Focused Brief Therapy (SFBT) Framework With Children Experiencing Personal And School Related Problems

This thesis is submitted to the University of Newcastle in part fulfilment of the requirements for the

Doctorate in Educational Psychology

Pamela Grandison

2010

Dedication

I dedicate this to my parents, Violet and Bill Leveson, and to my sons, Paul and Steven Grandison.

Contents

Tables and Figures

List of Tables

List of Figures

Acknowledgements

Firstly I would like to thank the pupils with whom I worked. I enjoyed the time that I spent with them and I thank them for sharing their thoughts and feelings with me throughout our journey.

I would also like to thank the children's parents and teachers for contributing to this work and to the staff who made me so welcome in the school.

My thanks also go to my supervisors, Liz Todd and Simon Gibbs, for their advice and support. Thanks also to Sarah Hulme who read my final draft and helped clarify some of my thinking at this crucial stage.

And most especially, thanks to my husband, Ernie Brown, for his patience, tolerance and loving support during this whole process.

Declaration

I declare that this is my own original work and that no material has been submitted for any other award or qualification

Name: *Pamela Grandison*

Signature: P. M. Grandison

Date: 20-01-10

An Exploration Of The Use Of Eye Movement Desensitization And Reprocessing (EMDR) Techniques Within A Solution Focused Brief Therapy (SFBT) Framework With Children Experiencing Personal And School Related Problems

Abstract

This study was set in a mainstream primary school in Scotland where a group of children had been identified by their class teachers and parents as presenting as quiet, shy, withdrawn and/or anxious. The researcher was an educational psychologist in the local authority where the study took place. 5 primary aged children at stages P5, P6 and P7 (aged 9 to 11 years) of the Scottish Primary education system were involved in a group process in their school, consisting of 6 sessions over the course of 2 months. The intervention combined elements from Eye Movement Desensitization and Reprocessing (EMDR) and Solution Focused Brief Therapy (SFBT). This was a strength based approach which aimed to focus on positive strengths and increase resilience.

The individual nature of the therapy required a flexible model. A qualitative research methodology was used. The general aim of this research was to investigate this combined therapeutic process within an applied psychology perspective. The research set out to study the experiences of a group of children during and after they participated in the process. A further aim of the research was to explore the process from my own perspective as the therapist and facilitator.

Data was collected during and after each session and post intervention data was collected from children, parents and teachers. Interpretative Phenomenological Analysis (IPA) was used to analyse the data. Findings indicated that the children found the intervention helpful and they were able to identify particular aspects of SFBT and EMDR which they had found useful.

Chapter 1 Introduction and Background to the Research

1.1 The structure of the thesis: signposting the chapters

In this section I will signpost the work for the reader by providing a summary of each of the chapters.

Chapter 1 will provide the reader with an account of my personal story and relate this to the subject of my thesis. In this opening chapter I will focus on the rationale for my research and explain the context for this work. The chapter will also provide an introduction to the therapies that I have chosen to use in my research.

Chapter 2 will outline the theoretical orientation and provide an overview of the relevant literature. The chapter is in two sections. Section 1 will focus on Solution Focused Brief Therapy (SFBT) and section 2 will consider Eye Movement Desensitization and Reprocessing (EMDR).

Chapter 3 will describe how I developed the therapeutic intervention used in this research study based on a combination of SFBT and EMDR. The chapter starts by considering the similarities and differences in the two therapeutic approaches. It then describes how the approaches are used in practice. The chapter then describes how I combined elements from each of these approaches for the thesis.

Chapter 4 considers the methodology used in this research and links this with the literature.

Chapter 5 explains the process of moving from theory to practice. The chapter begins by providing details of the method of data collection, the choice of participants and the stages involved in setting up the group-work. Each of the group-work sessions is described together with my own reflections from each of the sessions. The chapter ends with my reflection on my experiences during the process as a whole.

Chapter 6 begins by providing a description of the method of analysis used in the research. The results from this analysis are provided together with a description of my own experience as therapist and facilitator of the group-work.

Chapter 7 provides a discussion of some of the issues arising from the research study. The chapter ends with my conclusions in respect of the work undertaken.

1.2 Personal Story

In the following section I will provide the reader with the background information to this study. I will also outline the context of the work and focus on the rationale, justification and aims of the research.

It is difficult to pinpoint exactly how and when my journey started, but as I reflect on my career, firstly as a teacher, then as an educational psychologist and as a psychotherapist I realise that the territory for me revolved around emotions and affect. I was particularly interested in how an individual viewed him or herself and the effect that this view had on his or her behaviour and the effect it had on the individual's life in general.

After qualifying from university I taught English in a number of mainstream secondary schools in Scotland and although I enjoyed teaching this subject at all levels I found myself drawn towards the child who appeared to be "struggling". This led me to a teaching job in a residential school for boys with social, emotional and behavioural difficulties and consequently to gaining a qualification in educational psychology. Alongside this, my interest in counselling and therapies continued to develop. Today as I reflect on my own journey towards the crystallisation of the subject of my thesis I realise that the germ of the idea for this work developed somewhere along the way as I followed my interest in therapy and the effect that this could have on an individual.

A Curriculum for Excellence, Scottish Government (2004) aspires to 'enable all children to develop their capacities as successful learners, confident individuals, responsible citizens and effective contributors to society'. In my work in schools, both as a teacher and as an educational psychologist, it seemed to me

that the education system did not fully address the power of self-efficacy in relation to a child's progress and achievement. For example, some children appeared to lack confidence even though they were able to do a task. These children often sought reassurance from their teachers.

The Standards in Scotland's Schools etc. Act 2000 (s2 (1)) places a duty on an education authority to 'secure that the education is directed to the development of the personality, talents and mental and physical abilities of the child or young person to their fullest potential'. It would be difficult to dispute this grand aspiration. However, I became increasingly aware as I visited schools in the course of my work as an educational psychologist that this aspiration was not being achieved for some children. As a practising educational psychologist working in a semi-rural area of Scotland it became evident during the course of my discussions with school staff that there were a number of children who did not reach the 'priority' in terms of accessing help from outside agencies such as psychological services. Teachers were aware of this group of children who were described by them as quiet, shy, withdrawn and/or anxious. However, the competing needs and demands of pupils with more challenging behaviour often meant that the quieter, less assertive children were less likely to receive more intensive help. It seemed to me that this group of children were often missed. Their needs were highlighted by their teachers and yet the system was not able to address the needs because of other priorities. In a sense this group of children

were on the cusp, neither fully coping in school, nor fully demanding of services such as psychological services.

1.3 Educational psychology and the current context

Traditional psychology focuses on problems, deficits and pathology. For example, children receive labels such as Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), Oppositional Defiance Disorder (ODD), etc. Writing in the late 1970s Gillham drew attention to the 'directions of change' for the profession of educational psychology. The Warnock report in1978, followed by the 1981 Education Act radically changed the conceptualisation of special educational needs from one of disabilities defined in medical terms to a model which focused on needs. This was encapsulated in legislation in Scotland in the form of the Record of Needs document which outlined a child's special educational needs and how these should be met. This legislation placed a duty on local authorities to meet these special educational needs. The result was to raise expectations amongst teachers and parents that additional resources would solve the child's problem.

My own training as an educational psychologist was in the early1980s at a time when there was an increasing move for educational psychologists to shift away from a medical model where difficulties were perceived as 'within child' and therefore requiring assessment, diagnosis and treatment. The move took the profession towards a social model, where the emphasis was on the environment

and the effect that this had on the child's learning and development. The focus, therefore, was on adjustment of factors in a child's environment, such as the curriculum and the classroom, in order that the child could progress. More recently the Education (Additional Support for Learning) (Scotland) Act 2004 was introduced in Scotland. This legislation removed the Record of Needs document and extended the focus of support to include a broader definition than was previously held under Warnock. The terminology has changed from individual needs to additional support needs with an emphasis on broader 'barriers to learning' which are extended to include emotional, social and medical factors that might affect a child's education. There is an acknowledgement, therefore, that a child's family and community environment can also have an effect on progress and learning. The Standards in Scotland's Schools etc. Act 2000 includes a 'presumption of mainstreaming'. This legislation supports the inclusion of children with additional support needs within the mainstream education system wherever possible, rather than in special schools.

Amongst professionals there is a heightened awareness, too, of the advantages of early intervention and preventive approaches rather than becoming involved reactively when a situation is in crisis. Recommendations from Scottish Government point the way for authorities to devise systems to reflect best practice (For Scotland's children report, 2001; Getting it Right for Every Child, 2008). The overarching concept of the national programme, Getting It Right for

Every Child, is a common, co-ordinated approach across all agencies that supports the delivery of appropriate, proportionate and timely help to all children as they need it. In my own authority a system of staged intervention is becoming embedded to respond to the principles contained in this national programme. However, my experience in practice was that despite current legislation, national guidelines and progress by the authority, there were still some children who faded into the background. They were the children who were described by their teachers as being of concern because they presented as quiet, shy, withdrawn and/or anxious. The teachers often voiced their concern that the children did not seem to be achieving their full potential. The question for me as I began my thesis journey was how did I, a practising educational psychologist working in a local authority psychological service in today's current shifting and complex landscape, attempt to remove or reduce some of the barriers to learning for this particular group of children.

1.4 Theoretical underpinnings

'Psychology is not just the study of disease, weakness and damage; it also is the study of strength and virtue. Treatment is not just fixing what is wrong; it also is building what is right' (Seligman, 2001, p.4).

Within the field of clinical psychology Martin Seligman changed the focus from the traditional study of problems and problem behaviour to the study of the development of positive psychological states in crucial areas of psychological

functioning. In 1998 Seligman urged psychologists to remember psychology's forgotten mission: to build human strength and nurture genius. Seligman named the new focus area 'positive psychology'. Not only did this new focus move away from a pathology model but went even further, viewing mental health and well-being as more than the absence of disease or disorder.

There is growing evidence that positive emotions and adaptive behaviours contribute to a satisfying and productive life. Findings from research into optimism and pessimism indicated that optimists tended to have better health outcomes than pessimists (Danner, Snowdon and Friesen, 2001). Writing in 2004, Peterson and Seligman focused on what is right about people. In order to nurture talent and make life more fulfilling, positive psychology focuses on three areas of human experience, the subjective, the individual and the group or societal level (Seligman and Csikszentmihalyi, 2000). Barbara Frederickson (2001) described a fresh theoretical perspective on emotions which she places within the broader framework of positive psychology. She reports on the limiting and narrow focus of negative emotions and contrasts this with the profound purpose of positive emotion. She suggests the function of positive emotions is broadening abiding intellectual, physical and social resources. The values and research findings emerging from positive psychology indicate that there are human strengths which act as buffers against serious problems and these can be fostered in children (Seligman and Csikszentmihalyi, 2000). Positive psychology then is about maximizing human potential. Positive

psychology did not dismiss the aim of curing illness. Seligman, 1998, acknowledged the work achieved in respect of treating mental illness. However, he asserted that the profession of psychology had been side-tracked resulting in the other two fundamentals missions of psychology, making the lives of all people better and nurturing genius, being forgotten. Seligman and colleagues working in the field of positive psychology raised the profile of preventive approaches and highlighted the view that there is a set of human strengths that are the most likely buffers against metal illness. My thesis drew upon the developing field of positive psychology as a backdrop to the therapeutic intervention which forms the basis of my research. For me it seems that the children who were quietly stuck in their schools could move forward if it was possible to find a way of maximizing their potential. I wanted to focus on 'strengths and resilience' rather than attempting to surface 'weakness and damage'. In effect, I wanted to find an approach with the children in my study which would do what Seligman urged the profession to do, namely, for practitioners to recognize that much of the best work they do is amplifying the strengths. This thesis sets out to attempt to emphasise this role of fostering strength.

My background training and experience is as a psychologist and psychotherapist. Craig (2007) makes the point that much of the current emphasis on psychology and counselling in today's culture is undermining the idea of self-realisation and leading instead to people feeling vulnerable and in need of constant help from

professionals. I agree that there is an inherent danger from a process of counselling or therapy which leads to a person becoming over-reliant on the therapist. It is my view that the therapist has an ethical responsibility to ensure that power is not removed from a child. Any plan that I developed would need to have the capacity within it for the participants to be able to have some power within the process. In the longer-term my hope would be that the children will not need to be referred to a specialist service but instead they would be able to rely on their own resilience.

According to the teachers I spoke to in my daily work, the children they had mentioned did not have many friends or achieve many successes in school, either academically or socially. A meta-analysis by Multon, Brown and Lent (1991) found a significant positive relationship between self-efficacy and persistence on academic tasks. People who have a sense of self-efficacy bounce back from failures; they approach things in terms of how to handle them rather than worrying about what can go wrong (Bandura, 1988). According to Seligman, 2004 self-efficacy involves the expectation of being able to exert control and perform effectively to bring about desired outcomes. Research also shows that self-efficacy influences motivation by determining goals people set for themselves, how much effort they expend to reach those goals, how long they persevere in the face of difficulty, and their resilience to failures (Multon, Brown & Lent, 1991). The description of the children given by their teachers was one where they did not appear to believe in their own abilities or seem able

to exert control and perform effectively to bring about desired outcomes. If indeed these children were limited by their self-beliefs then it seemed to me that I needed to find a way to help the children think differently about themselves. With this I mind I returned to see what Seligman had to say in this respect.

Martin Seligman refers to the "feeling good versus doing well" aspects of self esteem (Seligman, 1995). He sees the feeling of self-esteem as a by-product of doing well. Once a child's self-esteem is in place, it kindles further success. Seligman's view is that once self-esteem is in place tasks flow more seamlessly, troubles bounce off, and other children seem more receptive. Seligman separates what he calls the self-esteem movement in America which envisions the feeling good side of self-esteem. He points to the notion of self-esteem as proposed by James (1890) (as cited in Peterson & Seligman, 2004). This bridges two psychological functions: first, self-esteem is a feeling state, and second, such good feeling is rooted in the world, in the success of our commerce with the world. Seligman concludes that the whole issue of promoting feelings of self-esteem in children, on the one hand, and promoting mastery and optimism on the other, needs to be seen as a continuum. At the one end are those who believe that what is important is how a child feels about him or herself and at the other end those who believe, as Seligman does, that doing well in the world is what matters and the feeling side is a 'delicious by-product'. Seligman's views led me to consider where I sat on this continuum. At first it seemed to be somewhat of a chicken and egg argument. I certainly believed that if a child did

not feel good about him or herself then he or she was unlikely to have the energy or capacity to achieve. But equally I did not think that the positive words alone were enough. Surely a child needed some evidence that these words fitted with his or her experience. As I reflected on my own stance I realised that I sat somewhere towards the end of the continuum which believes that what is important is the success of our commerce with the world. But, I realised too that for me the two were inextricably linked. Having come to that conclusion I needed to consider how I could incorporate this in my study. I was interested in Seligman's explanation of the mental state that he sees as being related to self-esteem. He calls this the explanatory style and views this as considerably more potent than self-esteem. By explanatory style Seligman means the explanation that a child gives about blame when he does badly. In other words, how does the child attribute blame for any failure? Does he blame himself? Or, does he believe that the problem will last for ever and undermine everything. The former governs the feeling side of self-esteem. The latter attribution causes the child to stop trying. It is not the feeling bad about self that directly causes failure. It is the belief that problems will last forever and undermine everything. This leads to a cycle of events where giving up results in more failure and this then undermines feelings of self-esteem. If this is the case then it seemed to me that this could have detrimental effects on the later educational attainments and the personal well being of a child or young person. My experience working therapeutically with adults certainly appeared to support this.

My interest in therapy and the views put forward by Seligman led me to consider how I might devise an intervention around this subject. Seligman talks of the two new technologies; one for changing pessimism into optimism and one for changing helplessness into mastery (Seligman, 1995). The kernel of an idea for this current thesis grew from my experience working with adults whose self-limiting beliefs affected their lives. These beliefs often emanated from childhood. The children who were mentioned to me by the teachers as I visited schools were often described as not achieving their potential. Their teachers considered that the children were capable of achieving more and yet they seemed to have difficulties emotionally, socially and with their educational progress. It seemed to me that these children may have developed self-limiting beliefs and that these beliefs could impact on their future. It was becoming clearer where my journey was leading. My aim in this respect was to devise a method that would build on strengths and hopefully reduce or eliminate some of the self-limiting beliefs that might be barriers to the children realising their future potential.

1.5 What was the way forward?

A possible solution to my dilemma emerged from my interest and background training in a number of therapeutic approaches. In particular, I had been trained in the use of Eye Movement Desensitization and Reprocessing (EMDR) with children and adults. EMDR is a method of psychotherapy that engages clients in many traditional elements of other therapeutic methods organised in a unique

way (Lipke, 2000). EMDR was discovered 'incidentally' by Francine Shapiro in 1989. Shapiro developed the approach as a clinically integrative method, rather than a theoretically integrated method (Lipke, 2000). The background to EMDR grew from a psychopathology construct. In EMDR the person is asked to form an image of the problem situation together with the feelings this evokes and an awareness of these in the body. The person identifies a negative self-belief (cognition) that is held in relation to this problem situation and a self-rating scale is used to measure the intensity of the belief. A preferred positive cognition is ascertained and also rated. The procedure then consists of a series of bilateral stimulations using eye movements or tapping while the problem is processed by the person. The use of language on the part of the therapist is limited. (This approach will be described more fully in chapter 2, section 2).

Much of the documented research in this area has been with adults. EMDR has continued to be used by therapists and clinicians working in a wide variety of clinical fields. The largest body of research in EMDR has focused on the area of Trauma related problems, in particular, Post Traumatic Stress Disorder (PTSD). These events can be described as big "T" trauma (Shapiro & Forrest 1997; Shapiro, 2001). Shapiro posited that EMDR could also be effective in the treatment of small't' traumas. She refers to small-t trauma occurring in innocuous but upsetting experiences that daily life sends our way. These experiences can result in the same feelings as big "T" trauma and have far reaching effects on a person's life. Many events can be disturbing because of

their personal significance. Shapiro cites examples of small "t" trauma such as failing a grade at school or over-hearing a passing remark that you are unattractive. Shapiro asserts that EMDR is also effective with these small "t" traumas as the therapy deals directly with how the experience has affected the person. As I listened to the descriptions provided by the teachers in the schools that I visited in my work as an educational psychologist it seemed to me that some of the children they were concerned about appeared to fit the small "t" category. I wondered about the possibility of using EMDR with some of these children.

There has been less research on the effects of EMDR with children. In 1999, Robbie Dunton, coordinator of the EMDR Institute in California, made the point that whilst the number of clinicians using EMDR methodology had increased substantially over the previous ten years there were few publications documenting its efficacy and application to children. Tinker and Wilson (1999) also pointed up the lag in research on EMDR with children. The use of EMDR with children with learning difficulties was pioneered by Dunton (1992) who focused directly on unlearned material and used eye movements to install the newly learned material after she had taught it (Tinker & Wilson, 1999). Evidence from work with traumatised children has also had positive results (Greenwald, 1994; Lovett, 1997; Tinker & Wilson, 1999).

1.5.1 How could EMDR help the children who were 'stuck'?

As mentioned above, much of the research into EMDR has focused on individuals who present with unresolved distress following PTSD or a traumatic event or events. The children who were to be the focus of my study did not appear to have experienced a traumatic event of this magnitude. Yet, according to the perceptions of the teachers and parents, these children appeared to be emotionally stuck and this appeared to be interfering with their academic, social and emotional development.

My own experience as an educational psychologist using EMDR with children has led me to consider some of the issues involved. Unlike adults, children do not often present themselves to a therapist for assistance with a problem. More often they are directed to the psychologist or therapist by a concerned parent or teacher. Children can be resistant to therapy. Some children find it difficult to express their distress or may not be willing to focus on the distressing issue. Sometimes children do not have the language skills or the cognitive ability to follow the therapeutic process.

Some of the descriptions given by teachers of the children included references to the children's withdrawal and social isolation. They tended to sit quietly when stuck with a task and they did not seek assistance from the teacher. From these descriptions I gained a sense of children who believed that they had little or no power or control of their situation. It was therefore important that any

intervention that I used should encourage the children to gain a sense of control in their environment. For me the question was how I might find a way to help the children access some of the benefits of EMDR within a process that would utilize their strengths and resources in a way that would encourage in them a sense of having some control over their lives. This led me to consider an approach which I had used called Solution Focused Brief Therapy (SFBT). My experience of using SFBT with children had been positive. I decided to explore the possibility of incorporating this approach into my design.

1.5.2 What else was needed: could solution focused brief therapy be added?

SFBT is an approach to psychotherapy which fits with Seligman's views of positive psychology (de Shazer, 1985; Berg, 1994). This approach focuses on a person's strengths and competencies. It could be argued that there is a theoretical contradiction in combining a solution focused approach with one that is based in psychopathology. However, I had previously tried incorporating aspects from a solution focused approach into my work using EMDR with individual children. The feedback from these children had been positive. My intention in this study is to use EMDR in a way that would focus on strengths and positives rather than on difficulties and negative cognitions. This will be described in chapter 3.

Solution Focused Brief Therapy (SFBT) is an approach which frees up the therapist and the client from the pressures and stresses of discussing the

problem. Solution Focused Brief Therapy is a model of intervention that was developed and described by Steve de Shazer (1985, 1988, 1991); Insoo Kim Berg (1991) and their colleagues at Brief Family Therapy Center in Milwaukee. The approach was based on Milton Erickson's ideas about the resources that people have and how these can be utilised to effect change (Grinder, Delozier & Bandler, 1997). Erickson's assumption was that there is a natural desire for growth within a person (Haley, 1993). Based upon social constructionism, solution-focused therapists have developed a set of guiding principles for their practice (Durrant, 1992, 1993). Solution Focused Brief Therapy focuses on strength enhancement and uses the resources that the client has or potentially has. The premise is that people are resourceful but their problems do not allow them to notice their strengths and competencies, or the solution-orientated behaviour, which already exists. Therapists believe that it is easier and more profitable to construct solutions rather than dissolve problems (Berg, 1991). Problems are best resolved, not by understanding them but by understanding solution processes (Iveson, 1990). Exceptions to the problem-dominated behaviour pattern are viewed as clues for solutions and therefore require to be focused upon. By focusing on these the view is that people can develop constructs of themselves as being competent and in control. Bill O'Hanlon (1988), who was also influenced by the work of Erickson and by that of Carl Rogers (1991), developed a slightly different approach which he called Solution-oriented therapy. This varied from SFBT in a number of ways. One main difference is that the solution-oriented approach is less 'formulaic'. It also

places more emphasis on the emotions. Whilst my work drew from the techniques used in SFBT my approach tended to be more flexible and creative, in a sense following the solution-oriented tradition. (As I intend to draw on aspects from SFBT in my intervention I will use this name throughout my writing).

1.6 The way forward: a coming together

Sometimes the deep-seated beliefs that children hold about themselves are a block to them realising their full potential. Instead of the individual developing a construct of himself as competent and in control, some children hold self-limiting beliefs and see themselves as different from their peers and as failures academically and/or socially. SFBT and Solution-oriented approaches fit well with current philosophy which aims at empowering children, or at least giving them a voice (Wynesss, 2006), and with the trend within education to involve children in plans about their progress and learning.

Having considered the above, it seemed to me that for these children both EMDR and SFBT had something to offer. EMDR was developed as a clinically integrated method, rather than as a theoretically method of therapy (Lipke, 2000). Shapiro (1995) put forward accelerated information processing as a theoretical construct. The premise is based on a psychopathology model: when an individual suffers a traumatic event the normal information processing is blocked. Shapiro asserts that this results in painful emotion and negative

information getting stuck or held in the nervous system. Shapiro's (1995) clinical work suggests that adaptive reprocessing of painful emotions and self-beliefs can take place rapidly using the EMDR method. My own experience using EMDR had also demonstrated positive results. I was particularly interested in the speed of adaptive reprocessing that can take place. However, I did not subscribe to a deficit model. As explained earlier, I wanted to build on the children's strengths.

SFBT as a theoretical concept focused on an individual's strengths and resources and provided the tools to assist the facilitator to engage the child in the therapeutic process as well as helping the child to construct a more positive and resourceful construct of him or herself. This method certainly offered a means of focusing on strengths. Yet it did not appear to offer the speed of processing. Some of the children who would be taking part were described as quiet, shy, withdrawn and/or anxious. I was concerned that these children may not respond to a method that relied to a large extent on language.

Both of these methods offered something different as a way forward. The question for me was could I combine EMDR and SFBT as an integrated method of therapy? In addition, children who were displaying behaviours as described by the teachers in this study would not usually be referred to my service due to other priorities in a school. It was unlikely then, that the children would receive individual help from a service such as my own, yet it seemed to me that there

was an unmet need to be considered. I wanted to use an approach that could be embedded in practice. I therefore, needed to find a way of addressing the needs of the children in a more time efficient way. My solution was to consider a group approach. The question remaining for me was could an integrated method using EMDR and SFBT be applied successfully in a group setting? I needed now to consider the possibility of the integration of the different therapeutic approaches.

1.7 Counselling and Psychotherapy: the trend towards integrative approaches

Psychotherapy and counselling approaches derive from different theoretical backgrounds and are based on different philosophical premises. Some practitioners choose to combine approaches into the method that they use. In other words they integrate the approaches in the delivery of the therapy depending on the particular situation of the client. Psychotherapy integration is best characterized by attempts to look beyond and across the confines of single-school approaches in order to see what can be learned from – and how clients can benefit from - other perspectives (Arkowitz, 1992). Corey (1996) refers to integrative psychotherapy as the process of selecting concepts and methods from a variety of systems. My initial training as an applied psychologist involved studying the theoretical and practical aspects of a range of therapeutic approaches. Later my particular interest in therapy led me to train in specific areas: therapeutic counselling, hypnotherapy, EMDR and SFBT. My experience

within the field of counselling and psychotherapy over a period of time has steered me towards an integrative perspective when working with clients. In particular, my experience working with children has encouraged me to be creative and flexible within the therapeutic process, firstly, in order to help them to engage with the process, and secondly, to work with them to effect a positive change in their circumstances.

Norcross and Newman (1992) refer to two broad types of psychotherapy integration which they call "technical eclecticism" and "theoretical integration". Technical eclecticism is characterized by Norcross and Newman as focusing more on the differences and choosing techniques from various approaches without necessarily subscribing to the theories which underpin these approaches. The goal of theoretical integration, on the other hand, is viewed as the therapist producing a conceptual framework that synthesizes the best of two or more theoretical approaches under the assumption that the outcome will be richer than either of the theories alone (Norcross and Newman, 1992). The approach which I took within this work fell within the definition of theoretical integration. My goal when planning and implementing the work was to use some of the techniques from EMDR within a SFBT approach. As a therapist and practitioner I subscribe to the theoretical underpinnings of both of these approaches. My aim was to combine elements from both of these therapies into a unified therapeutic approach. The intervention would be used with children who were described by their teachers as displaying behaviour which indicated that they

were not confident either academically or socially despite appearing to their teachers to have more abilities. The intervention could have been carried out on an individual basis with a child. As mentioned earlier, the particular children who were the focus of this study did not usually reach the threshold for referral to the psychological service. I wanted to find a time efficient way of targeting the needs of this population. The programme was devised to be delivered within a group setting as a way of meeting these criteria.

1.8 What did the research aim to do?

The general aim of this research was to investigate this combined therapeutic process in the context of the Scottish Education System and in particular within an applied psychology perspective. The research set out to study the experiences of a group of children during and after they participated in a group process which combined two different therapeutic processes: Eye Movement Desensitization and Reprocessing (EMDR) and Solution Focused Brief Therapy (SFBT). A further aim of the research was to explore the process from my own perspective as the facilitator of the intervention. The main research questions were:

1. How do children experience a process which combines therapeutic approaches from the two distinct theoretical backgrounds of SFBT and EMDR?

The following subsidiary questions were identified:

i. Are the children able to identify aspects that they found useful from either of the therapies?

ii. Do the children use any of the skills that they have learned during the sessions outside of the therapy sessions?

iii. Do they combine any techniques from the two backgrounds?

iv. Is there any evidence that the therapy made a difference?

2. How does the therapist/facilitator experience this process?

1.9 What was the context?

The work is located in professional practice within the field of educational psychology. My own position is that of an educational psychologist working in an authority psychological service in Scotland. The context for the research is the 'real world' of school (Robson, 2002). My position is both researcher and participant in this study. This will be discussed in more detail in chapter 5 which describes the methodology used in this research.

Signposting to chapter 2

The next chapter will outline the theoretical orientation and provide an overview of the relevant literature. The chapter is in two sections. In the first section 1 will focus on the relevant literature from Solution Focused Brief Therapy. In the

second section I will consider the relevant literature from Eye Movement Desensitization and Reprocessing.

Chapter 2 Theoretical Orientation and Overview of the Literature

This chapter is divided into two sections. Section 1 will provide an overview of Solution Focused Brief Therapy (SFBT). Section 2 will provide an overview of Eye Movement Desensitization and Reprocessing (EMDR). I will look at the literature from both SFBT and EMDR to see how they fit with my proposed research. I will look at the origins of the approaches and review relevant literature from each approach to consider the evidence supporting each approach and to consider how I might use them in this current thesis.

Section 1: Solution Focused Brief Therapy

2.1 Origins of SFBT

Solution Focused Brief Therapy is a model of intervention that was developed and described by Steve de Shazer (1985, 1988, 1991), Insoo Kim Berg (1991) and their colleagues at Brief Family Therapy Center in Milwaukee. The approach had its origins within the brief strategic therapy movement. The method evolved to be used also with individuals.

2.2 Theoretical Orientation of Solution Focused Brief Therapy

De Shazer and colleagues developed the method in an attempt to move away from the brief problem-focused method of the Mental Research Institution. The method developed in an attempt to move away from the 'pathologising' of individuals. SFBT is underpinned by both social constructionism and systems

theory (Gergen, 1999; Lines, 2002; O'Connell, 1998). Usually called 'constructivism' or 'social constructionism' outside the context of philosophy, anti-realism is an epistemological doctrine whose underlying assumption is that individuals construct their own reality. SFBT marked a shift from expert and client to one where client and therapist construct meanings and understandings together. De Shazer (1991) asserted that '[w]hat a therapist and client do during the interview is akin to writing or coauthoring and reading text' (p.68). This influence of constructionist thinking means that the therapist views the therapeutic relationship as collaborative and co-constructive. Individuals construct their own realities based on the lenses they use and the distinctions they make (von Glasersfield, 1984). O'Hanlon and Weiner-Davis (1989) assert that there is no one right way to view things: different views may be just as valid and may fit the facts just as well. According to Gergen (1985) there are critical features of a social constructionist position. A critical stance is taken towards taken-for-granted knowledge, including ourselves. This was in opposition to positivism and empiricism in traditional science. This social constructionist position challenged the view that the world can be 'revealed' by observation. It encouraged a critical view of conventional knowledge and our perceptions of what the world appears to be. It emphasised the historical and cultural specificity of the categories and concepts that we hold. According to the social constructionist position, the concepts and categories are a product of the era and culture in which they are placed (Burr 2003). In social constructionism there is a focus on the processes rather than static entities. This

view fits with my own position and is located in the context of current educational policy as described in chapter 1. Knowledge is seen as being sustained by social processes. Our knowledge of the world is constructed through the daily interactions that we have with others in the course of social life. What we believe is the truth or knowledge is a product of the interactions people have with each other. Knowledge and social action is viewed as going together. The way we behave or the action we take is viewed as a consequence of the negotiated understandings - our construction of the world. This contrasts with the traditional psychology view which assumed the existence of internal traits, attitudes, motivations and cognitions as being responsible for actions and behaviours.

My research is located in the world of school and aims to work with a group of children who have been identified by their teachers as being of concern to them. The study aims to examine the experiences of the children during and after an intervention which draws on two therapeutic approaches, SFBT and EMDR. Social constructionism examines the structures, the practices and the interactions. The experiential nature of my research requires an epistemology located in social constructionism.

Gergen (1994) makes the point that shared negotiated knowledge is the basis for the development of shared values and standards and for a renewed emphasis on interaction and combined action. Social constructionism challenges many of the

basic assumptions of psychology and scientific research. For example, within traditional research an attempt was made to control for or eliminate contextual and cultural factors, whereas, in social constructionism the interest is on these contextual and cultural factors as a means of understanding what is being examined.

Within SFBT the imbalance of power of the traditional psychotherapies was relocated within a social constructionist perspective. Based upon social constructionism, solution-focused therapists have developed a set of guiding principles for their practice (Durrant, 1992, 1993). Social constructionism is influenced by philosophy, sociology and linguistics. It is about how knowledge is constructed rather than about the nature of the person or society (Gergen, 1994). Burr (1995) emphasises the role of language when she states '[w]hen people talk to each other the world gets constructed' (p.7). Social constructionism relocates the problems away from pathology. This fits with the current emphasis in educational psychology. As mentioned in chapter 1 psychology has moved away from a child deficit medical model of pathology towards a social model. SFBT seemed to me to offer an approach which would allow me to focus on strengths and competencies.

In SFBT the emphasis is more on processes than on structures. It takes a positive stance considering not what an individual has or hasn't, but instead considering how forms of knowledge are arrived at by people in interaction.

Within SFBT meanings are generated by the communications and interactions between the therapist and the client. Gergen (1994) states that '[i]t is human interchange that gives language its capacity to mean, and it must stand as the critical locus of concern' (p.264). Meanings are created through language. The therapist and the client construct meanings through shared action. The role of the therapist/facilitator is to take part in conversations and to facilitate the telling of stories. In this way the therapist and the client co-construct a new reality together. The client is able to explore new options or possibilities as a way of helping to bring about change. The focus is on solutions not problems. This approach also seemed to be compatible with what I was trying to achieve. I needed to use an approach that facilitated the process of therapy so that the children would be more likely to engage in this process.

The late 20th century endorsed the values of speed, productivity, efficiency and empowerment. According to Sarti (2003) SFBT mirrored this change. Sarti posited that many of the values underpinning solution focused therapy corresponded to the values of the era in which the approach developed. My aim was to carry out practitioner research which would encompass a best value approach to service delivery within the current context of applied educational psychology in Scotland in the 21st century. To do this I needed to find a method that would not involve long-term therapy. In addition, to use educational psychology time effectively my plan was to devise an intervention that could take place in a group setting rather than on an individual basis. Finally, from a

cost-effective point of view I wanted to offer early intervention in the hope that a preventative approach could reduce or eliminate the need for later more intensive work. In that sense, my plan fitted with national and local recommendations which aim at reducing barriers to learning within a staged approach. SFBT appeared to offer an effective and efficient use of resources. More importantly, the underlying epistemology of SFBT resonated with my own beliefs and the educational and legislative context where I worked. The constructionist approach seemed to fit well with current philosophy today which aims at empowering children and with the trend within education to involve children in plans about their progress and learning.

2.3 Evaluation of SFBT: What form has the research taken?

Research concerning SFBT has taken two forms, process research and outcome studies.

2.3.1 Early studies

Solution-focused therapy had its roots in the brief strategic therapy movement (Walzlawick, Weakland and Fisch, 1974). The approach evolved from within a clinical context and early evaluation studies included many anecdotal reports of its success from clients and therapists. De Shazer and Berg continued to develop their work on strategic therapy modifying the existing therapies as a result of their research based on feedback from clients about successful outcomes. Solution-focused therapy has an evidence base, which began with six evaluation

studies by 1994, increasing to 50 follow-up studies as well as at least 39 published smaller studies by 2006 (Macdonald, 2007). SFBT was only recently subjected to controlled empirical testing. The first systematic review of solution-focused therapy was published in 2000 (Gingerich and Eisengart, 2000).

2.3.2 Process research

As the approach was evolving de Shazer and the team at the Brief Family Therapy Center in Milwalkee conducted follow-up surveys of their clients. Early investigations were aimed at 'searching' for and finding out what works rather than about whether the approach works 'as well as' or 'better than' other approaches (de Shazer and Berg, 1997). In this sense the approach was evolving. Later follow-up studies indicated that diagnosis did little to predict outcome and the approach was successful regardless of the client's problem (Berg and De Jong, 1996). These findings fit with my aim to work with the children without focusing on what may be described as a problem in traditional terms.

The SFBT approach grew from a family therapy background and as such involved some of the features of this model of therapy. For example, a one way screen was employed in the early work with a team behind the screen providing feedback to the therapist. This component was later omitted. The assumptions that having a feedback team would make a difference to clients were disproved:

the presence or absence of a team behind the one-way screen had no impact on outcomes (Burr, 1993).

Process research is important as a means of indicating which components of SFBT are effective for which clients. De Shazer and Berg cautioned the research community of the dangers inherent in adopting a reductionist approach to researching SFBT. They were concerned that research methodology which focused on aggregates could lose some of the very core of the SFBT approach, namely, concern with the client's goals and the client's evaluation of his or her life. These early process studies on SFBT were useful in providing information as the approach was developing. As a result of early process research the model evolved into what de Shazer and Berg described as a minimalistic approach. The protocol which developed from this early feedback was not rigid but it included a number of characteristics which could be used in later research to indicate that solution-focused brief therapy was happening (de Shazer and Berg, 1997). In this sense although early studies were not rigorous and did not meet the traditional empirical criteria for scientific research such as Randomised Control Trials (RCT), the ground was prepared by de Shazer and Berg for criteria against which later research could be measured. The following characteristic features of SFBT identified by de Shazer and Berg are now being used in research studies focusing on SFBT:

i. at some point in the first interview, the therapist will ask the 'Miracle Question'

ii. at least once during the first interview and at subsequent ones, the client will be asked to rate something on a scale of '0 to 10' or '1 to 10';

iii. at some point during the interview, the therapist will take a break

iv. after this intermission, the therapist will give the client some comliments which will sometimes (frequently) be followed by a suggestion or homework task (frequently called an 'experiment').

The different criteria used in evaluating research studies on SFBT make it difficult to compare results from some of the therapeutic work carried out by the many practitioners now using SFBT or a derivative of this original method. For example, solution oriented approaches developed by O'Hanlon and Weiner-Davis (1989) and other solution-focused approaches are being used widely. Stobie et al (2005) drew attention to the fact that, although UK educational psychologists are using solution-focused approaches in their practice, there is a dearth of evidence of effectiveness of solution-focused practice in the UK. Stobie calls for educational psychologists to evidence what particular solution-focused methods lead to the attainment of client goals in the context of school problems. I am one of the educational psychologists who uses solution-focused approaches in my work and I agree with Stobie on the need to evidence practice in this respect. I intend to incorporate the characteristic features identified by de

Shazer as one of the elements within an integrated method of psychotherapy (with the exception of taking a break).

2.4 Outcome studies

The use of SFBT was increasing and was being used in a wide range of contexts in the United States and in other countries including Britain. There were many anecdotal reports of successful outcomes and high client satisfaction.

Early follow-up surveys at 6 to 18 months were carried out by de Shazer and the team at the Brief Family Therapy Center in Milwaukee. These examined treatment outcome by asking clients if they had met their goals for therapy or felt that significant progress had been made. 82% success rate was reported on follow-up of 28 clients (de Shazer, 1985). A success rate of 72% was reported with a sample of 1600 cases (de Shazer *et al.*1986). This success was upheld by other clinicians (De Jong & Hopwood, 1996). These studies provided subjective evidence of success of SFBT from the clients who had received this intervention. Other clinicians outside of the team at the Brief Family Therapy Center have found similar although slightly lower results using subjective measures (Lee, 1997; Morrison *et al.* 1993; Schorr, 1997).

Schorr (1997) took the research of SFBT further using a pre-post design to investigate outcomes following SFBT presented in a group context. At pre-test 67% of the group members scored in the clinical range on the State-Trait Anger

Inventory. On post-test after 8 group sessions this had reduced to 40% of the group members scoring in the clinical range on this measure.

These early studies using subjective measures provided indications of the efficacy of the approach. However, these studies lacked experimental control and therefore it is not possible to draw causal inferences from the results.

2.5 Randomised controlled outcome studies

More recently controlled studies began to appear in the literature. These have been slow to develop, however, and still remain limited. Currently, 5 randomised controlled studies have been reported in the literature.

Lindforss and Magnusson (1997) carried out a study in Sweden examining the effects of SFBT treatment with prisoners entering a Swedish prison for re-offenders. In this study prisoners were allocated to experimental group or the control group on an alternating basis as they entered the prison. The experimental group received on average 5 sessions of SFBT treatment addressing their own chosen problem to work on. The measures used were re-offending rates and details of any subsequent offences. The results from this study were reported in two phases, pilot study and main study.

Pilot study: In the experimental group 66% (14 of 21 subjects) had re-offended at 20 month follow-up, compared with 90% (19 of 21 subjects) in the control group.

Main study: In the experimental group 60% (18 of 30 subjects) had re-offended at 16 month follow-up compared with 86% (25 of 29 subjects) in the control group. There had also been 3 deaths in the control group.

Knekt and Lindfors (2004) are involved in a major study in Finland with clients with depressive disorders and anxiety disorders. This study examines the effects of 4 different forms of brief psychotherapy, including SFBT. The results reported so far found no statistically significant difference between the different forms of psychotherapy. There are indications that SFBT appears to be effective more quickly in depression. However, although SFBT appears to be effective more quickly than the other short-term therapies, a fuller reporting on the comparisons carried out do not appear to have taken account of other differences between treatments. The number of sessions used in each treatment was different, as were the timescales during which the therapies took place. On average 10 sessions of SFBT were provided, whereas, 15 sessions of other psychotherapies were delivered. Similarly, SFBT took place over 7.5 months, whereas, the other treatments took place over 5.7 months. Whilst it is possible that these aspects may not have resulted in a significant difference in outcome, the amount of treatment provided and the duration of any treatment has

implications for practice. For example, as an educational psychologist working in a local authority psychological service, delivery of any intervention has to be considered in the context of the effective and efficient use of resources. In addition, before embarking on a particular course of action consideration has to be given to certain aspects. One such consideration is the appropriateness of an intervention on the basis of the 'least intrusive' intervention for that child or young person. The results from the Finish study indicate that there was no difference in outcome for the clients whichever short-term therapy they received. However, further investigation and discussion concerning the amount of therapy provided and the duration of treatment received, would be helpful in adding a further dimension to the reporting of the results in the context of decisions to be made by practitioners in field. A further strand of this major study which looks at long-term psychotherapy has still to be published and may add further insight into these areas.

Cockburn, Thomas and Cockburn (1997) compared SFBT treatment with standard rehabilitation treatment with patients following orthopaedic treatment due to sustaining injuries at work. The experimental group consisting of 25 patients received 6 sessions of SFBT. The control group consisting of 23 patients received the standard treatment package normally delivered as rehabilitation to orthopaedic patients. 68% of the experimental group returned to work after 7 days whereas only 7% of the control group had returned to work within 7 days. This study indicates that SFBT could offer a brief and effective

intervention to address the recovery and rehabilitation of this client group. Whilst this outcome on its own cannot be said to determine the future, if the results found in this study are able to be replicated and found to be generalisable, there could be positive benefits both for the health service and to the workplace.

Wilmshurst (2002) used solution focused (SF) techniques in a study carried out in Texas with youths with emotional and behavioural disorders. Youths were randomly allocated to one of two treatment conditions for 12 weeks. One group (38) received a community based programme based on Cognitive Behaviour Therapy (CBT) together with 48 hours of family contact. The other group (27) attended a residential programme for 5 days each week. The programme consisted of the use of SF methods, together with 26 hours of family contact. This study did not adhere to the traditional SFBT method. However, I have included it as the population studied is relevant to my own study. At 12 month follow-up there were improvements in total behaviour in both groups. Attention Deficit Hyperactivity Disorder (ADHD) had improved in 63% of the group who had received the CBT based programme, compared with 22 % in the group who had received the SF programme. Grouped scores for depression had reduced by 26 % in the CBT condition compared to 11 % in the SF condition. The results in this study are equivocal. The programmes had a number of differences other than the CBT and SF elements. In particular, the fact that one took place in a residential setting and the other was community based has implications for the

interpretation of any outcome results. These programmes were not comparing like with like and therefore the results need to be treated with caution.

There are obvious difficulties in extrapolating from the results of some of the current outcome studies on SFBT due to some of the other factors that may have influenced the outcome other than the technique itself. Furthermore, an added difficulty has emerged over time due to the development of the therapy itself. Although the early work of de Shazer and Berg identified key characteristic features of SFBT, the method has now developed and is used flexibly and creatively beyond the pure method devised be de Shazer and his colleagues.

An initial split with the approach came when O'Hanlon and Weiner-Davis (1989) developed a Solution-Oriented (SO) therapy model. One of the major differences in this model is that some 'problem talk' is accepted as therapeutically useful. Whereas in the 'pure' SFBT model as developed by de Shazer and Berg, problem talk is not viewed as helpful, O'Hanlon and Weiner-Davis were of the opinion that the client needed to 'feel heard', albeit that problem-talk was kept at a minimum. My position subscribes to both of these models to some extent. My experience when working with adults is that for some adults it is helpful to spend a very short time at the beginning of the first session listening to the client's perception of the problem so that he feels 'heard', whereas with other adults rehearsing a problem can serve to reinforce it. However, when working with children I agree with de Shazer's view that

problem talk is not helpful. In my study I do not want to surface problems for the children and in this respect I will adhere to de Shazer's SFBT approach.

O'Hanlon claims that both he and de Shazer were developing their work at the same time based on the work of Erickson. De Shazer and his colleagues wrote up and published their work first and, according to O'Hanlon, were therefore credited as founders of the approach. O'Hanlon and colleagues developed a Solution Oriented (SO) approach, more flexible than the structure devised by de Shazer yet subscribing to the underlying theoretical underpinnings of SFBT. SO therapy does not necessarily utilize all of the criteria described by de Shazer. My plan is to draw on the criteria described by de Shazer. In this sense I will be working in the field of SFBT. However, I plan to use the techniques from SFBT in a creative manner, rather than sticking closely to the structure of a SFBT interview as described by de Shazer. In this sense the delivery of the method will be to some extent within a SO philosophy. My experience when working with children leads me to favour an approach which offers flexibility of design. This is likely to be particularly beneficial when working with a group of children who may be at different stages of development. O'Hanlon went on to develop the approach further and named this "Possibility Therapy" which is concerned with acknowledging and validating the 'felt' experience of a client and his ideas about his life while at the same time identifying possibilities for change (O'Hanlon and Beadle, 1997; O'Hanlon and Weiner-Davis, 1989). My study is concerned with the experiences of the children and my own experiences

of the process. In this sense the influences of 'Possibility Therapy' have a bearing on my work. Having acknowledged the influences underpinning my approach in this respect I will refer to the method as SFBT for simplicity and due to the fact that I intend to incorporate techniques as described by de Shazer.

2.6 Meta-analyses

Gingerich and Eisengart (2000) highlighted the need for objective, empirical evidence of the effectiveness of SFBT - evidence that the clients are better off in demonstrable and meaningful ways as a result of the intervention. Gingerich and Eisengart critically reviewed all the available outcome studies of SFBT up to and including 1999, (N=15) to consider to what extent there was empirical support for the effectiveness of SFBT. By controlled studies these researchers meant studies that employed some degree of experimental control. In other words, the researchers used a comparison group or single case repeated measures design. By client outcomes they meant client behaviour or functioning. Studies that reported only client satisfaction were excluded. The 15 studies were divided into 3 categories based on the above: well-controlled studies (5), moderately-controlled studies (4) and poorly-controlled studies (6). The critique used the standards for assessing empirical support for psychological treatments developed by the American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures (1995) as guidelines.

Gengerich and Eisengart concluded that all five of the well-controlled studies reported significant benefits from SFBT. Four (Cockburn, Thomas and Cockburn, 1997; Linforss and Magnusson, 1997; Seagram 1997; Zimmerman, Jacobsen, MacIntyre and Watson, 1996) found SFBT to be significantly better than no treatment or standard institutional services. However, it was not possible to conclude that the outcomes were due specifically to SFBT intervention as opposed to general attention effects, since the studies did not compare SFBT with another psychotherapeutic intervention. Sundstrom, (1993) designed the first randomised experimental study of SFBT. She compared SFBT with the Interpersonal Psychotherapy for Depression (IPT), a known treatment, and found SFBT produced equivalent outcomes. There were no significant differences.

Since none of the studies met the stringent criteria for efficacy studies, and all five studied different populations with no replications by independent researchers, Gingerich and Eisengert were unable to conclude that SFBT had been shown to be efficacious. However, Gingerich and Eisengert conclude that the five studies in the well-controlled group provide initial support for the efficacy of SFBT. The moderately and poorly-controlled studies were deemed to contain methodological limitations and therefore it was not possible for firm conclusions to be drawn from this work. Gengerich and Eisengart make the point that they were unable to determine how representative these studies were of all outcome studies to date. However, they go on to suggest that all 15 studies

indicate the progress that is being made in attempts to use empirical methods to examine SFBT. By summer 2001 Gingerich and Eisengart had updated their study with a finding of 7 strong, 5 moderate and 6 poor studies. 17 of the 18 studies reported client improvement, with 10 studies being statistically significant. 7 of the 11 comparing solution-focused therapy with other treatments found solution-focused therapy to be better than standard treatment.

The number of studies meeting stringent research criteria is still limited. However, there is a move towards more rigorously controlled studies. Gingerich and Eisengart conclude that the studies they reviewed, the earlier follow-up studies, clinician reports and the growing number of pilot studies that are now taking place indicate a favourable foundation for conducting more rigorously controlled investigations to provide more conclusive evidence for the efficacy of SFBT. Although not meeting stringent research criteria, this meta analyses is useful in drawing together some of the evidence.

Some of the work evaluated above looks at comparisons with other psychotherapies. Whilst this is obviously useful and must be borne in mind when considering the efficacy of approaches, the daily work of an educational psychologist often requires a more pragmatic approach.

> *The most important thing is not to know which of our current methods are best, rather, to have a means of moving forward to develop even*

better methods in the future. That can only happen if the research is devised to determine why methods work in particular circumstances and not just whether they are better than alternatives (Rutter, 1999a, p.169).

This fits with my own study in the sense that I wanted to explore the children's experiences and their views on what seemed to work for them. The increasing focus on evidence-based practice for educational psychologists in Scotland supports my intention to ground my research in practice (HMIe 2007).

2.7 SFBT with children and young people

The literature indicates a growing and favourable body of evidence supporting the efficacy of SFBT with adults. However, my aim was to work with children in a school situation. It was important, therefore, to look at SFBT literature with children. The use of SFBT in schools and with children is a relatively new application of the SFBT approach (Durrant 1993; Kral 1987; Rhodes and Ajmal 2004). Research in this area is varied and increasing. The following studies used SFBT with children presenting with behavioural difficulties.

In a 6 to 12 month follow-up study of 55 children and young people who had received SFBT treatment in a children's clinic in Germany, 34 were traced. 77% (26) of these children had improved (Burr, 1993). Of the children who were traced the results are promising particularly since the improvements appear to have remained over time. However, this differs from my own study as the

therapy was carried out in a clinic setting and was delivered on an individual basis. I intend to work with a group of children in school.

Morrison and colleagues (1993) carried out a study in a school setting. These researchers used solution-focused questioning within a systemic approach in relation to behaviour problems in school. School staff and parents were invited to the meetings with the child. Behaviour improved in 78% (23 of the 30 children). What was particularly relevant for me in this study was the fact that the work was embedded in the school structure rather than in a clinic setting. Educational psychologists in Scotland work at the level of the school (Scottish Executive, 2002). Interventions are designed wherever possible to be integrated into a school system as the environment where the child develops and learns (Bronfenbrenner, 1979).

The following studies on SFBT with children are also relevant to my research. Cruz and Litterell (1998) did a 2 week follow-up after 2 sessions of SFBT to 16 American high school students. 10 of the students had achieved 54.7 % of their goals at this time. Results were more positive in a similar study carried out by Thomson and Littrell (2000) with 12 students. Follow-up at 2 weeks found that 10 students had achieved 100% of their goals. It could be argued that these results could be subject to therapist bias as the therapist who had been involved in the therapy also did the follow up. Lee (1997) reports on a 6-month follow-up by telephone following SFBT (averaging 5.5 sessions) with 59 North American

families whose children were experiencing a variety of behaviour problems. Improvements were reported by 64.9%. The possible effect of therapist bias was reduced in this study as independent raters were used. Whilst it could be argued that the previous studies did not result in a dramatic result in terms of the students achieving their goals it is also interesting to note that some of the students said that they would have liked more sessions. This could have been due to the individual attention the students received during the sessions rather than as a result of SFBT itself. However, it is possible to surmise that these students had found the sessions helpful to some extent but that the treatment had not been sufficient in terms of improvements.

One of the children who had been mentioned to me by her teacher was described as having learning difficulties. Her attainments were below those of her peers. I was therefore interested in studies that focused on children with learning difficulties. At one month follow-up, Franklin *et al.* (2001) reported improvement in all of 7 children previously described as having learning problems. Objective measures were gathered for one month prior to the seven session therapy input and these were repeated during therapy. They were then followed up one month later. There was some improvement in all of the children and 6 of the 7 children were considered as recovered. The children in this study were described as having learning problems. It is possible that these had as their basis an emotional component rather than a cognitive one and the SFBT treatment enabled the children to reframe their perception of themselves

as learners. This is an aspect that will be discussed later in the context of my own research.

2.8 SFBT research with groups

The previous studies had focused on individual therapeutic intervention in different settings. I planned to work with the children in my study in a group setting. It was relevant to examine what the literature indicated in relation to the use of SFBT with groups.

Three studies are of particular relevance to the design of my study which uses a group setting. Zimmerman, Prest and Wetzel (1997) looked at the effectiveness of SFBT with couples. Zimmerman, Jacobson, MacIntyre and Watson (1996) investigated parenting issues. Schorr (1997) followed up on work with anger reduction. All of these studies concluded that a SFBT intervention within a group setting successfully addressed the presenting issues. Newsome (2005) delivered 8 group sessions to 26 junior high school students. At a 6 week follow-up improvements were found in social skills, classroom behaviour and homework completion.

Although the literature is limited in relation to the use of SFBT in a group context the outcomes so far are promising.

2.9 Relevance to the current thesis

Although solution-focused group-work is a relatively new development, there is a growing body of research to suggest its effectiveness as a therapeutic intervention (Sharry, 2001). The studies investigating the use of SFBT in a group setting are of particular relevance to my research. I intend to use a group setting to work with children using a therapeutic approach which draws upon SFBT. In addition to the above studies with children and with groups, the following studies have particular relevance to my proposed intervention.

Springer *et al.* (2000) provided 6 sessions of group treatment to 5 Hispanic school children whose parents were incarcerated. The treatment programme consisted of solution-focused, interactional and mutual aid approaches. Findings were reported as a 'possibly significant' increase in self-esteem. This study is of interest to my current work in a number of ways. Firstly, the design used in the Springer study has similarities with my own design in that therapy was delivered to school children, the context for delivery was a group setting and the approach included SF methods with other approaches. Secondly, Springer's finding that there was a possible significant increase in self-esteem in the experimental group is of interest in the context of the particular children within my study who were said by their teachers and parents to have low self-esteem.

Beybach *et al.* 2000 report a better outcome for individuals with problems such as anxiety, depression or addictions than for those with relationship conflicts.

This was the first study to report on a difference in outcome based on problem type. The Beybach study reports on outcomes in relation to particular problems such as anxiety. Some of the children assigned to my own intervention were described by their teachers and parents as being anxious.

Stoddart *et al.* (2001) used solution-focused therapy with clients who were developmentally delayed. They carried out a comparison study with their existing clients who also had developmental delay. This comparison group had received a long-term psychotherapy programme. One finding from this study was that the fewer problems and the less developmental delay a client had, the better the outcome. This is perhaps an expected outcome. However, it is of relevance to my study in that I had to make a decision on whether or not to include a child with developmental delay and learning difficulties in the group. Another relevant finding from this study was that predictors of success were found to be 'having real-life goals' and being self-referred. The children in my study were not self-referred. However, I plan to offer the children a choice of opting in or out of the group-work. Having real-life goals will also be an aspect of the design.

2.10 Conclusion

Few outcome studies of SFBT use quantitative outcome research which provides convincing evidence and few use comparative measures comparing SFBT with another psychotherapeutic approach (McKeel, 1999). Despite this,

McKeel concludes from a selected review of research of solution-focused brief therapy that indications are that the literature presents consistent evidence that SFBT is effective and that it is an effective treatment for a broad range of problems. The number of outcome studies of SFBT has grown considerably since the early days of its development in the early eighties. However, the number of well-controlled scientific studies meeting the stringent criteria outlined by de Shazer and Berg still remains limited. On the other hand, clinicians working in many different fields are using SFBT as a method of choice. The reports providing feedback from their clients, albeit subjective measures, indicate a high level of client satisfaction. It is however, mainly practitioners and presumably advocates of the SFBT method, who are carrying out these investigations. The results of these studies, therefore, need to be considered with this in mind. There remains a need for more independent and objective empirical research to validate this growing bank of findings which continue to offer support to the SFBT approach.

It can be seen from the studies outlined above in this chapter, that solution work now takes many forms. The versatility of this has meant that the approach has spread from the therapy clinic to be used by practitioners in wide and diverse settings such as education, health and prisons. It is now used with populations with emotional, behavioural and relationship difficulties as well as for work with addictions and offending behaviour. Solution-focused approaches have now been incorporated into the work of educational psychologists (EPs)

practising throughout the UK. In spite of the fact that there is anecdotal evidence that many EPs use solution-focused methods in their practice, little has been published about the nature and evaluation of such practice (Stobie *et al.* 2005). Stobie carried out a computer-mediated exploratory survey which suggests that solution-focused interventions are attractive to educational psychologists not least because of the 'tools 'involved and the strong emphasis on 'change' rather than a search for the roots of the problem (Stobie, op cit). The approach is practical and readily assimilated into these real world contexts. Stobie suggests that practising educational psychologists using solution-focused approaches should include a research orientation. McKeel (1996) makes the point that since research helped the founders of SFBT to develop effective techniques, re-establishing the link between research and practice will lead other solution-focused practitioners to discover new, effective ideas to add to the model.

Robust empirical evidence in the field of SFBT and solution-oriented approaches is growing and continues to grow. For example, The European Brief Therapy Association (EBTA) has developed a multi-center research project to study the connection between sfbt techniques and objective measures of progress including a one-year follow-up with clients. However, SFBT was developed as a clinically based approach. It had its beginnings in a social constructionist orientation. As such, it could be argued that the requirement for understandings of a qualitative nature remains high. One recent attempt to do

this Rees (2005) examined the experiences of adolescents and educational psychologists using SFBT to overcome Social, Emotional and Behavioural Difficulties. More investigations need to take place asking clients about their experience of SFBT.

Section summary and signposting

Section 1 of this chapter has considered the rationale and provided an overview of Solution Focused Brief Therapy. The review of the literature has provided evidence that the approach would fit with my aims and the theoretical underpinnings of positive psychology as outlined in chapter 1. Positive psychology is about maximising human potential. The Standards in Scotland's Schools etc Act 2000 points up the duty of an education authority towards the development of a child's fullest potential. It seemed to me that SFBT could provide me with a framework to deliver a therapeutic intervention which could focus on and highlight the strengths and resources that the children in my study might already have at their disposal.

I wanted to explore the use of EMDR as a means of deepening some of these positive strengths. The following section of this chapter examines the Eye Movement Desensitization and Reprocessing (EMDR) literature in relation to my aim.

Section 2 Eye Movement Desensitization and Reprocessing

As described in chapter 1 my professional training had included training in Eye Movement Desensitization and Reprocessing (EMDR) and I am a fully accredited practitioner and consultant in this approach. Following this training I have used EMDR therapy when working with individuals who were suffering distress after experiencing a traumatic event in their lives and clients have reported positive results after this treatment. My experience of using EMDR with children has also been positive. However, I found that some children did not seem to be able or wish to engage with the process when it focused on a negative event in their lives which had resulted in them being referred to me by their parents or teachers. My proposed thesis developed from my desire to find a way to engage such children in therapy in an attempt to reduce some of the distress they were experiencing in their lives that seemed to be getting in the way of them realising their potential.

The literature outlined in section 1 of this chapter indicated that SFBT could provide a useful framework for my proposed intervention. This offered a positive forward looking approach which met my requirements to focus on strengths and resources with the children. SFBT also appeared to be compatible with my intention to work in a group setting rather than with an individual child. I now needed to explore the literature on EMDR to see if this approach could be combined with SFBT. I also wanted to consider the possible use of EMDR as a

positive resource rather than one that began by focusing on negative aspects in the children's lives.

This chapter starts by providing the reader with a summary of the background to EMDR. This is followed by an examination of the relevant literature on EMDR in relation to my thesis. The chapter also includes my own thoughts on how EMDR as a therapeutic approach might fit with the proposed thesis.

2.12 Theoretical Orientation of Eye Movement Desensitization and Reprocessing

EMDR is a method of psychotherapy that engages clients in many traditional elements of other therapeutic methods, organised in a unique way (Lipke 2000). EMDR was discovered incidentally by Francine Shapiro in 1987 and introduced to the field in 1989 with a published randomised controlled study that evaluated one-session treatment effects with traumatized individuals (Shapiro, 1989). Shapiro changed the name from eye movement desensitization (EMD) in 1990 to reflect a shift in paradigm. Shapiro developed the approach as a clinically integrative method, rather than a theoretically integrated method (Lipke, 2000; Shapiro 1995). Following a discovery that rapid, repetitive eye movements had a powerful effect in reducing anxiety, Shapiro developed the work within her clinical practice. In other words, the therapy was developed from clinical practice rather than based on a theoretical model. Shapiro developed the theory later. In 1995 she developed the Accelerated Information Processing model to describe and predict the effect of EMDR. Shapiro extended this into the

Adaptive Information Processing model (AIP) to broad its applicability (2001). Over subsequent years, it was discovered that other forms of bilateral stimulation such as taps or tones were also effective (Shapiro, 1991, 1994). The background to EMDR grew from a psychopathology construct. The underlying mechanism of EMDR is not yet fully known. Shapiro's conceptualisation for EMDR starts from the premise that learning-based psychopathology is the result of affectively painful evaluation and other 'negative' information held in the nervous system (Lipke, 2000). This conceptualization is based on a representation of experience being stored in the brain in a dysfunctional, incompletely processed manner. In other words, the normal processing of information does not fully occur. Clinical experience noting the effects of the method with clients led Shapiro to put forward the theoretical construct of accelerated information processing as a framework to explain how EMDR might operate as a therapeutic approach. The AIP model is based on the understanding that we process events through our thoughts, feelings, visual images and behaviour. The basic concept is that when a person experiences a traumatic event in his or her life then the representation of that experience being stored in the brain is held in a dysfunctionally incompletely processed manner. The trauma information is stored in a neuro network that is isolated and unable to integrate with information stored in other neuro networks. In other words the person can get "stuck" in a negative self-belief that they can intellectually see is untrue from some perspectives, but remains true from others (Lipke, 2000). Some people are able to work through the problem over time but others get

stuck and could experience debilitating effects such as nightmares, flashbacks, anxieties, phobias or anger. The intensity of the traumatic event or events can result in a person being stuck in relation to emotional, behavioural or cognitive material that has not been processed in an adaptive way (Tinker & Wilson, 1999). Shapiro's model posits that EMDR links up these neuro networks though the process of bilateral stimulation.

Various models have been proposed in an attempt to understand how EMDR works. In her original description Shapiro suggested that the directed eye movements mimic saccades of rapid eye movement sleep (REM). As described earlier in this chapter, an accelerated information processing model was put forward by Shapiro (1989) as a possible explanation of how EMDR works. More recently, models have focused on the growing knowledge from the field of neurobiology and neuroscience. Stickgold (2002) suggests that the repetitive redirecting of attention in EMDR induces a neurobiological state similar to REM sleep which is optimally configured to support the cortical integration of traumatic memories into general semantic networks. He goes on to suggest that this integration can then lead to a reduction in the strength of the hippocapally mediated episodic memories of the traumatic event and also a reduction in the memories' associated amygdala-dependent negative affect (Stickgold, 2002). Both the amygdala and hippocampus are integral for processing information from the body to the cerebral cortex. The amygdala processes the storage of emotions and is involved in reactions to emotionally charged events. The

hippocampus processes the data required to make sense of those experiences within a timeline. In the EMDR process the alternating bilateral stimulation leads the client to constantly shift his attention across the midline. The suggestion is that it is this orienting response that induces a REM-like state which facilitates cortical integration of a traumatic memory. Other writers in the field have proposed more psychologically based models. For example, it is suggested that the orienting response in EMDR enhances inter-hemispheric communication and synchronous neuronal firing patterns (Lipke, 1995, 2000; Servan-Schreiber, 2000). The growing body of knowledge in the field of neurodevelopment is adding to the understandings of how EMDR might be working (Perry, 2002, 2009).

An exact understanding of how EMDR operates is still unclear. EMDR has links with traditional behavioural learning theory and with cognitive neurobiological approaches. At this stage in our knowledge of the brain, any psychological theory should be regarded as tentative and incomplete (Zabukovec, Lazrove & Shapiro, 2000). Current thinking focuses on the ability of EMDR to induce an altered mind-brain state in which processing of traumatic memories can occur and move towards an effective resolution. Preliminary evidence indicates that changes in brain activation patterns may follow effective treatment (Levin, Lazrove & van der Kolk, 1999). At this time hypothesis about neurobiological mechanisms involved in EMDR are speculative. The

development of advanced brain imaging techniques offers the possibility of adding to the knowledge in this area.

Although still a relatively new psychotherapy there is a growing body of evidence to support its efficacy. The following section will explore what the literature on EMDR has to say.

2.13 EMDR: What does the literature say?

This section provides an overview of some of the relevant studies in the field of EMDR in relation to adults and to children. Research studies have predominantly been carried out with adults. Some studies with children are appearing in the literature but there appears to be a gap. My study will be carried out with children but in order to consider the evidence on EMDR as a therapeutic approach I will begin by looking more broadly at the area. My review will begin by examining what the literature says in relation to the use of EMDR with adults. I will then examine the literature on the use of EMDR with children.

Early studies

In her initial seminal study in 1989 Shapiro presented one 60-minute EMDR treatment session to 22 survivors of rape, childhood abuse and war. All involved reported that their memories had lost most of the devastating charge and that

their irrational, negative self-attributions and presenting complaints had greatly improved. In a follow-up at three months this improvement had remained. A control group that simply called up a memory without using eye movement showed no relief (Shapiro, 1989). Greenwald (1994) suggests there were limitations to this study. He makes the point that diagnostic criteria were unclear and the only standardised measures were self-report.

There were only 6 Randomised Control Trials (RCTs) across all psychological treatments for PTSD up until 1992 (Solomon *et al.* 1992). Shapiro (1999) made the point that given the paucity of controlled treatment outcome literature with people suffering from Post Traumatic Stress Disorder (PTSD) the effectiveness of the procedure in EMDR was subjected to close scrutiny. Since then more studies have appeared in the literature. There have been over 100 case studies and over 20 RCTs to 2005 (http://www.emdr-europe.org/research.htm). Although there has been considerable empirical evidence for the validation of EMDR there have been some studies which do not uphold this. For example, (Oswalt, Anderson, Hagstrom and Berkowitz (1993) found that the EMDR treatment used was successful with only 3 of the 8 volunteers with the most seriously disturbed showing the least benefit.

Limitations of the Early Studies

There has been some criticism of early studies on theoretical and methodological limitations. Some studies have been conducted using Shapiro's

original protocol although she modified this (Shapiro, 1989). Shapiro changed the name to reflect a personal change in orientation from the initial behavioural formulation of simple desensitization of anxiety to a more integrative information processing paradigm. She emphasises that the early work on EMDR had been revised yet some of the studies reported in the literature were based on earlier procedure and misinformation (Shapiro, 1999).

Shapiro (1985) makes the point that some studies have been conducted with clear deviations from the method. Some of the criticism of the early studies is around the issue of fidelity to the method. For example, Renfrey and Spates (1994) used inaccurate instructions. In the standard EMDR protocol the client is asked to rate his positive cognition to provide a baseline and to ensure that the positive cognition is possible. However, these researchers rated the negative cognition rather than rating the positive cognition as required in the method. The results are therefore not valid.

Another criticism of some of the early studies is on the grounds of sample size and the number of sessions of EMDR sessions involved in relation to the level of trauma. Perkins and Rouanzoin (2002) review the literature and make the point that sample sizes have not been large enough to assess the effects of the components of EMDR treatment. The number of sessions used in a treatment also causes confusion with some researchers. Some studies were designed around brief interventions despite the clients being multiply traumatised. The

findings from these studies were not favourable. Montgomery and Ayllon (1994) reported that although there were reports of subjective relief from PTSD symptoms, this was less than previously reported findings. Positive results were reported after 6 sessions of EMDR rather than the 1 or 2 reported previously by Shapiro. However, these studies were not comparing like with like. Shapiro's participants had suffered a single event trauma. Although 2 to 3 sessions can be effective for some single event traumas the number of sessions required for those who have experienced multiple traumas is much higher (Carlson *et al.* 1998).

It is clear from the literature that there are a number of criticisms that can be made of the early studies into EMDR. In the next section I will consider the later studies to see what can be learned in relation to my thesis.

Later studies

The early studies of EMDR were followed by studies involving improved methodological rigour and improved design.

Randomised control studies with war veteran population

A full course of EMDR treatment was provided for combat veterans who were multiply traumatised. 12 sessions of EMDR eliminated PTSD in 77% of the multiply traumatised veterans with effects maintained at follow-up (Carlson *et al.* 1998). In this study 35 Vietnam combat veterans with PTSD were randomly assigned to a wait-list control group, or to 12 treatment sessions of biofeedback

relaxation, or to EMDR treatment sessions. The EMDR group was found to have significantly lower scores on measures of PTSD and depression at post-test than the wait-list group. At a follow-up at 3 months the EMDR group was found to have significantly lower scores than the subjects in the bio-feedback relaxation group on measures of PTSD and self-reported symptoms. The strength of this study is that it includes a comparison with another treatment with the therapist involved in each treatment having therapist allegiance. It controls for the often neglected variable for therapist allegiance (Hollon, 1999).

Wilson, Becker and Tinker undertook a comprehensive study in 1995 with 80 subjects who were suffering from a range of trauma including combat trauma. Participants were randomly assigned to one of two groups: immediate treatment or delayed treatment. The participants in the immediate treatment group received three 90-minute EMDR treatment sessions. All showed a reduction in the presenting complaints and a reduction in anxiety as rated by a skeptical independent assessor. The participants who had been assigned to delayed treatment showed no improvement during the 30 day delay period but after undergoing the same EMDR treatment as the original group they showed similar improvement on all measures. Effect sizes were too large for the results to be due to a placebo effect. Effects were maintained at a 90-day follow-up.

The above studies examined the effect of EMDR with a population suffering from combat trauma. The studies provide some evidence for the efficacy of

EMDR with the treatment population involved. My proposed study will not be with this level of trauma. I needed to see what the literature had to say about the use of EMDR with other types of issues. Also, as I do not intend to carry out long term therapy, I wanted to examine the literature for shorter interventions using EMDR.

Brief treatments with psychologically distressed civilians

The following studies were carried out with adults suffering from psychological distress for reasons other than combat related. All of these could be termed brief in contrast to longer term traditional therapies.

EMDR treatment was provided for victims of sexual assault who were suffering from PTSD. In 3 sessions of 90 minutes PTSD was eliminated in 90% of the rape victims (Rothbaum *et al.* 1997).

3 sessions of EMDR treatment provided to individuals who were psychologically traumatised produced clinically significant change on multiple measures (Wilson *et al.* 1997). Treatment effects were maintained at 15 months.

2 sessions of EMDR treatment delivered to psychologically traumatised young women reduced psychological distress and brought scores within one standard deviation of the norm (Scheck et al, 1998).

Four controlled studies examined the effectiveness of EMDR on single-trauma PTSD with 107 subjects who had undergone EMDR treatment (Marcus *et al.*1997; Rothbaum *et al.* 1997; Scheck *et al.* 1998). After the equivalent of three 90-minute sessions 84 to 100% of these subjects were no longer diagnosed as having PTSD at post-test. This study is based on a large number of subjects and the research findings are based on four controlled studies. The rate of improvement after only three sessions of EMDR is high. The study was carried out using independent research teams which addresses some of the criticisms of possible bias due to therapist allegiance.

What does the literature tell us so far?

Although EMDR is a relatively new therapy, the literature indicates an increasing number of studies examining the effects of EMDR with individuals. There were methodological flaws in some of the earlier studies. However, the later studies involved more robust methodological rigour. In 1995 a project was initiated by the American Psychological Association (APA) Division 12 Task Force on Psychological Interventions to investigate the degree to which therapeutic methods were supported by solid empirical evidence. Independent reviewers working under the auspices of the APA concluded that EMDR, along with exposure therapy and stress inoculation treatment (SIT), were among the therapies which were deemed "empirically validated treatments" as "probably efficacious for civilian PTSD".

No comparison was made at this time between therapies. Since then a number of comparison studies have been carried out. However, as EMDR is a recent therapy there is not the same level of evidence as some of the more established therapies. For that reason I decided to examine what the literature had to say about EMDR in relation to other more established approaches.

Comparison Studies

In a study comparing EMDR and prolonged exposure treatment both treatments resulted in a significant reduction of PTSD and depression symptoms. 70% of the EMDR group achieved a good outcome in three active treatment sessions compared with 29% of those who had received exposure treatment. There were also fewer dropouts from therapy in the EMDR treatment (Ironson *et al.* 2002). In EMDR it could be said that there are parallels to exposure treatment when the client is asked to visualise a target memory. However, if EMDR is a form of exposure then it differs from prolonged exposure treatment in that it is in vitro rather than direct and any exposure is short. This method may be less threatening to an individual than being exposed directly to a fear. If this is the case then this may to some extent explain the lower dropout rate in the EMDR group. It may also be that exposure in vitro is more effective for similar reasons. There did not seem to be the same differential between treatments when prolonged exposure treatment was compared with EMDR for rape victims suffering from PTSD. Both groups did equally well. However, EMDR used no homework whereas prolonged exposure did (Rothbaum *et al.* 2005). Other

treatments have used homework as an addition to the method being compared with EMDR. This makes it impossible to make a true comparison between these therapies. For example, EMDR was compared with exposure therapy and with relaxation training (Taylor *et al.* 2003). Exposure therapy was statistically superior to EMDR on 2 out of 10 sub-scales. Yet this treatment included 50 hours of homework.

It can be seen from the above studies that it is difficult to draw definite conclusions from these comparison studies when there are so many variables involved.

EMDR and currently prescribed medical treatment

One of the currently preferred treatments by the medical profession is Cognitive Behaviour Therapy (CBT). EMDR was compared with (CBT) for sexually abused girls (Jaberghaden *et al.* 2004). Both treatments produced a significant reduction in PTSD and in behaviour problems. EMDR was found to be significantly more efficient and only required approximately half of the number of sessions than CBT. A meta-analysis carried out by Seidler & Wagner (2006) upheld the finding that EMDR and CBT were equally efficacious. If this evidence continues to be upheld then referrals from General Practitioners (GPs) requesting EMDR could increase.

van der Kolk (2007) carried out another study of interest in relation to current medical treatment for depression. EMDR was compared with Fluoxetine and pill placebo in the treatment of PTSD. EMDR was found to be superior to Fluoxetine and to pill placebo condition in the amelioration of both PTSD symptoms and depression. Those in the EMDR group continued to improve whereas those who were in the Fluoxetine group again became symptomatic. Work in this area is continuing and if results continue to be favourable it could lead to a change in preferred treatments for depression.

Conclusion from the comparison studies

The evidence from the literature on comparison studies indicates that EMDR does well as a method of treatment for PTSD and depression. Also, EMDR does not use the additional homework sessions which are utilised by the other behavioural therapies. In that sense it could be said to be more efficient. The evidence from comparison studies with Fluoxetine is limited at this time but could be promising. It is also interesting to note that the National Institute for Clinical Excellence (NICE) now name both EMDR and CBT as the recommended treatments for PTSD in their guidelines.

Where then does this examination of the EMDR literature take me on my quest to identify a method to use in my research study? Implications from the research that I have reviewed so far indicate that, although EMDR is a relatively new therapy, there is strong evidence for its efficacy, not only with a population with

PTSD, but also in response to individuals experiencing psychological distress from a range of other events. It seemed to me, however, that the majority of studies had focused on adults. I needed to search the literature to see what studies there were on the use of EMDR as an approach with children. The next section will consider this.

2.14 What is the evidence for using EMDR with children?

Shapiro's original protocol for EMDR was devised for adults. For example, EMDR has been used with combat veterans (Daniels, Lipke, Richardson and Silver, 1992); victims of grief and loss (Puk, 1991; Soloman and Shapiro, 1997); burn victims (McCann, 1992).

Definitive, controlled research on applying EMDR to children has not yet been published. Only a few case studies about EMDR with children exist in the literature (Tinker and Wilson, 1999). As mentioned in chapter 1 Robbie Dunton, co-coordinator of the EMDR Institute in California in 1999, made the point that whilst the number of clinicians using EMDR methodology had increased substantially over the previous ten years there were few publications documenting its efficacy and application to children. Tinker and Wilson (1999) offer an explanation of this lag in research with children. They assert that the lack of research with children is due to the fact that Shapiro's original protocol was devised for adults. They also make the point that many more clinicians work with adults than with children. It was recognised by Tinker and Wilson

that there was a need for the original EMDR protocol to be modified for use with children. Tinker and Wilson produced a modified protocol to be used with children to accommodate the developmental stage of the child (Tinker and Wilson, 1999, p73).

Evidence from work with traumatised children has shown positive results (Greenwald, 1994; Tinker & Wilson 1999; Lovett, 1999). Chemtob and Nakashima (1996) carried out a field study using EMDR in a group format with treatment resistant traumatised children in Kauai, Hawaii following Hurricane Iniki. The results suggest that EMDR is also effective with children. After 3 sessions of EMDR to 32 children there were indications of a reduction in both anxiety and depression with gains maintained at a 6 month follow-up.

Consistent with the adult literature on trauma treatment, the treatments that have the most empirical support are cognitive behavioural therapy (CBT) variants and EMDR (Greenwald, 2004). Available data on EMDR with traumatized children and adolescents, including several controlled studies, for example, (Chemtob, Nakashima, Hamada & Carlson, 2002; Puffer, Greenwald, & Elrod, 1998), appear to indicate similar effect across age groups. Chemtob (2002) compared EMDR against waitlist for children aged from 6 to 12 years, who three years after a hurricane and one year after previous treatment still had PTSD. Three weekly sessions of EMDR were provided. The evidence is inconclusive and so it was not possible to determine if there was a clinically

important difference between EMDR and waitlist on reducing the severity of PTSD symptoms, or on depression. This was the first controlled study that examined the treatment of children with PTSD. A controlled study of EMDR for boys with conduct problems found that the addition of 3 sessions of EMDR resulted in large and significant reductions of memory-related distress, and problem behaviours by the time of a 2 month follow-up (Soberman *et al.* 2002). It has been recognised that although preliminary research on child/adolescent trauma treatment indicates that EMDR has shown promise in successfully reducing post-traumatic symptoms as well as conduct problem symptoms it can be difficult to secure 'treatment compliance' with child and adolescent population with persistent conduct problems (Greenwald, 2002). Greenwald asserted that in order to facilitate acceptance of trauma focused treatments, motivation, safety and self-efficacy issues must be addressed. My experience accords with this. My study will be designed with this in mind.

Some studies have been carried out with children with learning difficulties. Weinberg and Caspers (1997) carried out a pilot study using EMDR (as cited by Greenwald, 2001). The group of six boys was randomly allocated to two groups. Both groups received a 10-minute individual treatment session twice a week for eight weeks focusing on a recent difficult or upsetting situation that had occurred in school. The experimental group was given EMDR, whereas, with the control group the situations were just discussed. All three of the children in the EMDR group, as well as one in the control group, made rather dramatic

gains on various measures of reading and writing skills; the other two in the control group showed little change. In the follow-up study similar findings were reported although not all of those receiving EMDR responded as positively. This was a small study but it adds to the innovative use of EMDR, particularly with children. It is possible that the reported gains in reading and writing skills could be attributed to increased self-efficacy as a result of the EMDR. Shapiro (2001) highlights increased self-efficacy as one of the by-products of the adaptive processing of disturbing memories which she found in her own clinical work with EMDR and from reports from trained clinicians.

Armstrong (2007) carried out a research study which focused on the experiences of children who have undertaken and completed an episode of EMDR therapy for the resolution for simple trauma. The purpose of this study was to develop a better understanding of the approach from the point of view of the 'young traumatized patients' themselves. Despite initial skepticism the children became increasingly motivated and reported high levels of satisfaction with the therapeutic outcomes. Armstrong reports that some of the reflections from the children on the process of EMDR offer tantalizing glimpses into positive mechanisms underlying how EMDR works. She suggests that the dual focus of attention helped the children to concentrate better and thus to talk easily about traumatic memories and that the eye movements helped them relax and make the memories fade. This research study differs from mine as it focused on trauma. Also, the therapy was carried out with individual children rather than in

a group. However, it has similarities to mine as the study focused on the children's experiences. Armstrong concludes that further research would enrich the knowledge base by encouraging the voice of the child. My own study intends to do this - not from a mental health perspective - but from a perspective of health and well-being.

As outlined in chapter1, I was interested in Seligman's ideas and particularly his ideas around changing pessimism into optimism and changing helplessness into mastery. It seemed to me from my interrogation of the EMDR literature that an intervention using EMDR might be a way of addressing this. In addition, the literature examining EMDR with children is limited compared to that of the adult population. Much of this literature with children has focused on internal within child traits that need treating. My position, as described earlier, is located within a social constructionist stance. I needed to find a way to reconcile my position with that of an approach that derived from a pathological model. I also needed to consider how I might modify the standard EMDR protocol in order to achieve this.

Where does the examination of the literature with children lead me?

There are now a growing number of clinicians, myself included, who have gone on to extend their training in EMDR to include the specific EMDR training for use with children. I have found this approach useful in practice and have worked creatively with children of all ages. Tinker and Wilson (1999) propose

the principle of 'minimal creativity' when working with children. This means that the standard EMDR protocol is modified as much as is required to meet the developmental needs of the child. The need for creativity within the process is acknowledged. Tinker and Wilson also suggest possible targets for starting EMDR work with children. Although it is possible to start by targeting a traumatic event or disturbing memory, Tinker and Wilson suggest that various targets can act as a starting point for EMDR with children. For example, the work can start by targeting positive events such as when the child felt good about himself or a time when he felt that he had achieved at something. The over-riding aims when working with children, like adults, are to keep them safe, respect them, build rapport and help them to engage in the therapeutic process. These will be borne in mind at all times during my work.

The main differences when working with children, in my view, is the need for greater creativity and an approach which offers flexibility within the method. It seemed to me that EMDR could offer this. I needed to design a method that would allow opportunities for flexibility and I needed to consider the techniques that I could incorporate into an integrated therapeutic approach within a solution focused framework. In order to decide if there were elements within the EMDR method that would be able to be used effectively I returned to the EMDR literature.

2.15 Dismantling studies: eye movement and bilaterality

Various dismantling studies which examine the individual elements of EMDR have been carried out in an attempt to identify the effects of the component parts of the EMDR process. These will be outlined below.

Eye Movements

Studies have focused on the role of eye movements. Shapiro (1989, 1995) reported a possible relationship between oculomotor behaviour and the decrease in negative thoughts and emotions. A number of authors conclude that eye movements are superfluous (Herbert *et al.* 2000; Lohr,1998; McNally, 1999). However, in a study carried out by (Montgomery and Ayllon, 1994) the conclusion drawn was that no statistically significant reduction in the Subjective Unit of Distress (SUDs) occurred without the use of eye movements. With the use of eye movements there was a significant reduction in the subjects self-reports of distress. Other researchers, Chemtob *et al.* (2000); Feske, (1998); Spector and Read, (1999) assert that the role of eye movements is inconclusive. Perkins and Rouanzoin (2002) agree with this and call for more research to determine the role of eye movements in the EMDR process.

Although named 'eye movement' in the title of the method, later work identified that other forms of bilateral stimulation, such as, tapping or use of audio tones were effective. Indeed, Shapiro herself commented on this being a misnomer and regretted using it initially. Therapist directed eye-movements are the most

commonly used external stimulus but a variety of other stimuli including hand-tapping and aural stimulation are often used (Shapiro,1995). It is commonly agreed that eye movements or other dual attention stimulation produces an orienting response. In this respect 3 different models have been put forward in an attempt to explain this orienting response in EMDR. The models proposed are: a cognitive information processing model (Andrade *et al.* 1997; Lipke, 1999); a neurobiological model (Bergmann, 1998, 2000; Stickgold, 2002); a behavioural model (Armstrong and Vaughan, 1996; Barrowcliff et al, 2003; MacCulloch and Feldman,1996) (sourced from http://www.emdr-europe.org/research.htm). In 1997 van der Kolk posited that eye movement or other alternating right to left stimulation promotes the movement of information from one hemisphere of the brain to the other through the corpus callosum.

It can be seen from the above dismantling studies that exactly how bilateral stimulation works is not yet clear. However, it is clear that any therapy claiming to sit within the domain of EMDR must include some form of dual stimulation. Most of the work using EMDR has been carried out with individuals. As my study will be carried out with a group I needed to consider the literature in this setting.

2.16 Group-work using EMDR

EMDR's use with children and adolescents has come a long way since EMDR was introduced in 1989. There have been a growing number of reports by

therapists using EMDR with children. EMDR is typically delivered within an individual therapy context. However, the need for therapists involved in crisis intervention work to respond quickly to a large number of individuals, often involving children, has led to the development of adapted EMDR protocols to be delivered in a group context. This section provides a summary of some of this work with particular relevance to my own thesis.

Following Hurricane Paulina in Acapulco, Lucinda Artigas (1997) developed what came to be known as the "Butterfly Hug" Artigas *et al.* (2000). This was a Dual Attention Stimulation which was based on an adaptation of the original EMDR protocol. The technique involves teaching the children to alternate taps across the midline using right hand to left shoulder and left hand to right shoulder. The technique was used successfully in a group intervention with children at a developmental age of seven or eight. The intervention used drawings and focused initially on the hurricane event and negative cognitions. This work led to the use of the butterfly hug as a technique to focus on self-help and calming with children and adults. Artigas was honoured in 2000 by the EMDR International Association with the Creative Innovation Award. The technique developed by Artigas looks promising in relation to my own study.

The following case-study is relevant to some extent as it includes aspects of EMDR and its delivery that are similar to my intention to work in a group setting using elements of EMDR. Karen Forte (1999) reported using EMDR

successfully with a group of disadvantaged children aged between five and eight years of age. This work included developing internal resources such as a safe place or a person. This internal resource was strengthened using alternating hand claps. In addition to EMDR these children were taught resiliency skills. The use of techniques to develop internal resources fit with my intended research aims. Forte used other activities such as homework tasks and the teaching of resiliency skills. Whilst this is not a criticism of the approach, the use of these additional elements, introduces another component other than EMDR which may have had a bearing on the results. This research design differs from my own in a number of ways: Forte worked individually with each child in turn using clapping, while the other children in the group worked on a project. I do not intend to work with each child individually. Instead, I intend to design an approach whereby I can include the whole group in the therapy rather than working with the children one at a time.

Although I am aware this will require a creative and flexible design if the therapy is going to be beneficial to each child within the group. My task will be to design the method in such a way that I can address the individual situation for each child within this group approach. Much of the group-work currently carried out in schools is designed to target a specific issue which is common to each member of the group. For example, the focus may be on increasing social skills or managing behaviour. Instead, I plan to focus on a specific target for each child which would be relevant for that child at an individual level. In this

way I hope to address the issues of motivational factors and personal relevance discussed in chapter 1. The group interventions with children that I have reviewed in the literature on EMDR have been in response to major events such as hurricanes or other disasters. The target for the therapy, therefore, has been the trauma or negative event. Again this differs from my own plan which is to design an intervention that uses EMDR without targeting a trauma or anxiety. I plan to focus on a positive aspect for the children and attempt to strengthen the children's inner resources rather than targeting a negative event. My method will not adhere to the standard EMDR protocol. Instead, I intend to use a more flexible approach.

The butterfly hug technique as devised by Artigas is a technique that I have used in my work with adults who are distressed. This seemed to me a useful component to consider incorporating in my work with the children in my study. However, I needed to search the EMDR literature further to consider what I could learn from the literature that was more particular in respect of my intended focus as described above.

Shapiro (1995) makes the point that eye movements or other bilateral stimulation increase or further develop positive feelings or experiences. It would seem that using bilateral stimulation of some kind could be a useful component for my design. Also, Resource Development and Installation (RDI) is a method of psychotherapy developed by Andrew Leeds. RDI combines bilateral

stimulation with an individual's positive images, memories, and body sensations. This work contributed to the evolution of EMDR theory and method (Leeds, 1998; Leeds and Shapiro, 2000). RDI is a creative and flexible procedure that must be adapted to the unique needs of each patient (Leeds and Shapiro, 2000). This procedure can be used for example with clients who are suffering from complex posttraumatic stress disorder. Clients who have suffered multiple or complex trauma can be emotionally vulnerable and may not be ready for trauma work. Clinical reports indicate that the RDI procedure can be used to prepare more complex clients with affect disregulation (Korn & Leeds, 2002). RDI can be used to develop positive resources in a client and as such is used to prepare some clients with the necessary resources before proceeding to target a trauma or traumas. Although I was not going to be working with traumatized or extremely distressed children it seemed to me that aspects of RDI could be useful in contributing to the development of my own intervention. The approach was devised to develop inner resources and coping strategies in these vulnerable clients. It seemed to me that I could draw on this method in my intervention to strengthen the children's resources. In addition, the butterfly hug could be a useful technique for me to incorporate in my method to help the children to focus on self-help and calming.

2.17 Conclusion

From the literature reviewed it appears that there has been considerable empirical validation of Eye Movement Desensitization and Reprocessing

(EMDR). The largest body of research in EMDR has focused on the area of Trauma related problems, in particular, Post Traumatic Stress Disorder (PTSD). Indications are that differences in outcome of the various studies were related to methodological factors (Maxfield and Hyer 2002). These reviewers concluded from this investigation that greater weight can be put on those studies with better methodology. Those studies support the efficacy of EMDR as a treatment for PTSD. Positive therapeutic results with EMDR have also been reported in a wide range of problem areas including small 't' traumas, phobias and conduct problems.

Some of the difficulties associated with the findings on the efficacy of EMDR are that many of the researchers in the field are also committed practitioners who have experienced first hand the therapy. Whilst on the one hand this is understandable and indeed admirable from a practice based research perspective, it also has the possibility of adding bias to the studies or to a review of the research in the area of EMDR. In an attempt to evaluate EMDR and to clarify points of confusion (Perkins and Rouazoin, 2002) carried out a critical review of the literature. These writers were also practitioners of EMDR but attempted to take an impartial line in their review of the relevant literature. The value of the reviewers being familiar with the method and the procedure involved in EMDR removes any charge that the conclusions were based on misinformation. EMDR is an empirically developed therapy whose efficacy has been established by a number of scientific studies, even though it is unclear how or why its individual

procedures, including right/left stimulation, facilitate information processing of stored data about a traumatic experience (Zabukovec, Lazrove & Shapiro, 2000). An exact understanding of how EMDR operates is still unclear. Three models have been posited to explain the orienting response which is seen as a motor response of interest and attention to something new: a cognitive information processing model; a neurobiological model and a behavioural model. Work in this area continues.

2.18 Relating the reviewed literature to the current thesis

In this chapter so far I have reviewed relevant literature from SFBT and from EMDR. In the next section I will summarise how my reading of this literature and my background, including my therapeutic experience, have influenced my research design.

Although still a relatively new psychotherapy, since Shapiro's seminal study in 1989, the research findings so far provide a strong basis to support the efficacy of EMDR. As previously stated the largest body of research in EMDR has focused on the area of Trauma related problems, in particular, Post Traumatic Stress Disorder (PTSD). As I did not intend to focus on posttraumatic stress disorder or indeed what the literature refers to as big-T' traumas it was relevant to see what the EMDR literature had to say in respect of it's use in response to distress arising from what Shapiro referred to as small-'t' traumas. Much of the documented research in this area has been with adults. My own research will be

carried out with children. It was necessary, therefore, to take a look at what the EMDR literature showed in relation to children.

EMDR was designed not only to ameliorate experientially based psychological disorders, but also to optimize functioning and effect change in the emotional, cognitive and somatic domains Shapiro (2002). Shapiro (2001) makes the point that dual attention (bilateral stimulation) is merely one component integrated with procedural aspects synthesized from all the major psychological orientations. Shapiro (2001) makes the point that clinicians must use different protocols, depending on the types of pathology, and follow therapeutic procedure customized to the need of the client. She asserts that whilst one should always be cautious that untested additions to standardized protocols may diminish treatment effectiveness, it is important that innovation is not stifled. The current thesis is an attempt to create an innovative approach using EMDR in conjunction with Solution Focused Brief Therapy (SFBT).

My own experience as an educational psychologist using EMDR with children has led me to consider some of the issues involved. Unlike adults, children do not often present themselves to a therapist for assistance with a problem. More often they are directed to the therapist by a concerned parent or teacher. Often when a child is distressed or unhappy the exact cause is not always easily attributed to a particular event in that child's life. A child may not make a connection between the adult's concern and his own situation. Some children

find it difficult to express their distress or may not be willing to focus on the distressing issue. Sometimes children do not have the cognitive ability to follow the therapeutic process. Results using EMDR so far have encouraged me to consider how children can be helped further to engage in and have power within the process of EMDR.

EMDR, as it is currently practiced, is not a simple, by-the-book procedure dominated by the use of eye movements, but rather an integrated form of therapy incorporating aspects of many traditional psychological orientations (Shapiro, 1995). EMDR has continued to be used by therapists and clinicians working in a wide variety of clinical fields. Shapiro, herself, posited that EMDR could also be effective in the treatment of what she referred to as small 't' traumas, for example, single events such as a car accident. Small-'t' traumas can result in dysfunction. The memory of the event can elicit similar negative self-attributions, affect and physical sensations as existed on the day the memory was originally created (Shapiro, 2001). In practice clinicians trained in EMDR are using this method with other client populations other than PTSD. For example, EMDR has been reported to be useful in addressing the social and emotional effects of medically diagnosed disorders such as Attention Deficit Hyperactivity Disorder (ADHD). The behaviours that formed the basis of the diagnosis may indeed have been the result of early childhood trauma. There are indications that some children with a medical diagnosis of ADHD may be showing symptoms related to an earlier trauma (Tinker & Wilson, 1999; Lovett,

1999). Currently, there is limited research on this area. However, recent work on brain development has opened up the door to new thinking in this area.

EMDR admits a wide variety of theoretical models and is integrative in nature Shapiro (1995, 1999). The very integrated nature of the process opens it up to therapists from different schools of psychology. In this sense it fits with an approach which draws on an alternative therapeutic stance such as SFBT. EMDR uses a three-pronged approach that recognises the contributions and relationships between past trauma, the present, and expectations of the future (Shapiro, 1995). Solution Focused Brief Therapy (SFBT) in its pure form does not overtly discuss the client's problem or address the past in the sense of more traditional therapies. However, SFBT does utilize the contributions from the past in terms of identifying exceptions to the problem – times when things were better. It relates these to the present and to the future. In this sense, SFBT would appear to be compatible with EMDR. Having reviewed the relevant literature on SFBT and EMDR it seemed to me that there was a way forward. This will be discussed more fully in chapter 3, together with any contrasts between SFBT and EMDR. My thesis will attempt to address some of the gaps that I have identified in the EMDR literature. I will attempt to do this by:

i) contributing to the body of knowledge using EMDR with children;

ii) designing an integrated method which will draw from the SFBT tradition and from EMDR;

iii) using an integrated approach which will be carried out in a group setting rather than in an individual one to one situation;

iv) attempting to use this method to focus on strengths and inner resources without overtly focusing on difficulties or problems;

v) using an experiential approach in the design of the method to explore the experiences of the children and to explore my own experiences of the process.

Signposting to Chapter 3

The following chapter will describe how I developed the therapeutic intervention. SFBT and EMDR are compared in relation to their similarities and differences. This is followed by a consideration of how the two approaches might be combined into an approach which would suit the proposed study.

Chapter 3 Developing the Therapeutic Intervention

The theoretical orientations for SFBT and EMDR are described in chapter 2. This chapter will summarise the theoretical underpinnings of SFBT and EMDR and consider how these underpinnings lead to how each therapy is put into practice. I will then consider the differences and any similarities in the two approaches. The chapter then describes the elements from each approach that I propose to combine in my therapeutic intervention and my rationale for making this choice. The chapter concludes by explaining how this combined approach relates to my thesis.

3.1 Theoretical Orientation: Solution Focused Brief Therapy

As described more fully in chapter 2, section 1, SFBT is an approach based on Milton Erickson's ideas about the resources that people have and how these can be utilized to effect change (de Shazer, 1985). In SFBT the belief is that the person has the strengths and resources to resolve their own issues. Problems are best resolved not by understanding them but by understanding solution processes (Iveson, 1990). Individuals construct their own meanings by means of their interactions within a social context. They select and interpret social information. SFBT aims to re-shape this meaning construction process to create a more satisfying future (De Jong & Berg 2002, p.279). This is in conflict with the theoretical underpinnings of EMDR and needed to be reconciled in the method used in my study.

3.2 SFBT in practice

Practitioners have developed a set of assumptions, based on social constructionist philosophy, to guide their practice. Solution Focused Brief Therapy is an approach which focuses on what clients want to achieve through therapy rather than on the problem(s) that made them seek help. The approach does not focus on the past, but instead, focuses on the present and future. In SFBT the therapist focuses on problem free talk looking towards a clear objective for the future. The approach focuses on goals and empowerment. The emphasis is on questions aimed at identifying exceptions to the problem situation. The preferred future or miracle question is used to obtain a rich and detailed picture of life without the problem. Scaling questions are used to identify where the person views himself in relation to the situation and to move the process on towards the identified goals. The core practitioner skills of effective communication, good interpersonal skills and careful application of solution focused questioning are some of the key requisites to help facilitate change.

3.3 Theoretical Orientation: Eye Movement Desensitization and Reprocessing

The background to EMDR grew from a psychopathology construct. The underlying mechanism of EMDR is not yet fully known. EMDR is a method of psychotherapy that engages clients in many traditional elements of other

therapeutic methods. EMDR traditionally assumes a truth 'that a person has something wrong with them', for example, a trauma that leads to them being 'stuck' and that EMDR can fix this. The language used, for example, 'treatment' and 'assessment' exemplifies the medical model. The concept of 'treatment' conflicts with the fundamentals of SFBT where the aim is for the therapist and client to collaborate and co-construct together. Treatment, suggests an expert model where the therapist does something to the client to help make them better. 'Assessment' indicates a 'doing to' rather than a 'working together' process. As such EMDR does not appear to fit with a social constructionist epistemology stance.

3.4 EMDR in Practice

Francine Shapiro devised a standard Protocol for EMDR treatment consisting of eight phases, Shapiro (2001, pp.69-76).

Phase 1. History taking and formation of the treatment plan.

Phase 2. Preparation phase is where the therapist explains the procedures of EMDR and provides some expectation of what is involved.

Phase 3. Assessment consists of identifying the components of the target. The client identifies the negative self-belief (Negative Cognition) and a preferred positive belief (Positive Cognition). Baseline measures of the extent to which the individual holds this positive belief as true are established before any processing takes place.

Phase 4. Desensitization is the phase where the focus is on the negative affect. The client is asked to form an image of the target memory, to be aware of the feelings that go with that memory and where these feelings are experienced in the body. He then rates the intensity of the disturbance on the Subjective Unit of Disturbance Scale (SUDS). Processing then takes place using bilateral stimulation (eye movements or tapping).

Phase 5. Installation is the phase where the focus is on installing the positive belief and increasing the strength of this positive cognition.

Phase 6. Body Scan is where the client is asked to check for any residual tension in the form of body sensation and if necessary bilateral stimulation is used by the therapist to reduce any sensations.

Phase 7. Closure is the stage used to ensure that the client is fully grounded and in a state of emotional equilibrium.

Phase 8. Re-evaluation is used at the beginning of each session to check previously processed targets and to ascertain the client's responses.

3.5 SFBT and EMDR: what are the differences?

From the description provided above it can be seen that these differing viewpoints lead to a major difference in how the procedures are delivered. In particular, the initial focus of each intervention is structured differently. EMDR targets an image of the problem situation: SFBT focuses on the situation when the problem is not there. In this respect they could be said to be incompatible.

In SFBT the belief is that clients have the strengths and resources to resolve their own issues. This is a pragmatic approach which offers prescriptive techniques to interact with clients. The approach focuses on goals and empowerment. During therapy the therapist focuses on problem free talk looking towards a clear objective for the future. The emphasis is on questions aimed at identifying exceptions to the problem situation: occasions when the client was successful or when things were better. The preferred future or miracle question is used to obtain a rich and detailed picture of life without the problem. The view is that when a situation is experienced vividly in the imagination this can help the client to move forward, almost as if the experience had already happened in reality. Scaling questions are used to identify where the client views himself in relation to a situation and to move the process on towards the identified goals.

In EMDR therapy the therapist asks the client to form an image of the problem situation together with the feelings this evokes and a sense of where these feelings are experienced in the body. The client then identifies the negative self belief that he holds in relation to this problem situation and a self rating scale is used to measure the intensity of the belief. A preferred positive cognition is ascertained and this is also rated by the client. The procedure then consists of the therapist carrying out a series of eye movements or hand taps (bilateral stimulation) while the problem material is being processed by the client. The use of language on the part of the therapist is limited, the process mainly

following the responses of the client. The processing leads to a working through of the 'stuck' material from negative to positive, largely at an unconscious level. Once there is resolution, bilateral stimulation is used again to install the positive cognition along with the original memory. Finally the rating scales are used again to check that processing is complete.

From the perspective of EMDR when a person experiences a traumatic event in his or her life then the representation of that experience being stored in the brain is held in a dysfunctionally incompletely processed manner – the person can get "stuck" in a negative self-belief (Shapiro, 2001). (See chapter 2, section 2 for a fuller discussion). The premise is that EMDR therapy carried out by trained therapists can help a person to process the material that is preventing him from moving forward. Solution Focused Brief therapists, on the other hand, argue that problems are what get people stuck and to focus on these may lead to further 'stuckness' (de Shazer, 1985). These therapists view change processes as inevitable and constantly occurring (Berg, 1991). They believe that it is easier and more profitable to construct solutions than to dissolve problems.

SFBT relies heavily on the use of language and particular forms of questioning whereas in EMDR there is less language used and this is not prescriptive in nature. In SFBT the therapist works at a pragmatic level. Change is of a behavioural and cognitive nature. SFBT assumes that as people observe and interact with each other, their perception of reality changes. In EMDR,

cognitive, emotional and sensorial aspects are involved and the processing of distressing material from negative to positive leads the client to behave and experience differently.

The above describes the differences between the two therapies. The question for me was how to get round these differences in approach and reconcile them. To do this I needed to examine any similarities.

3.6 SFBT and EMDR what are the similarities?

On examining the two approaches there appeared to be some similarities. For example, the aim of each therapy was to help to empower the client and to help the person 'experience' their situation differently (although it is acknowledged that this could be claimed of any therapy). In that sense the client creates new meaning within the therapeutic process. Both approaches aimed to help the client function better in life outside the therapeutic sessions. In a sense in EMDR the client processes material at an unconscious level and then brings this to consciousness. SFBT is based on some of the approaches of Erickson. Erickson used hypnosis and unconscious processing in his work (Rosen, 1982). It is possible then that there is scope for merging the two processes of EMDR and SFBT using the imagery that both draw upon.

3.7 SFBT and EMDR: Taking them apart to put them together

In this section I will consider the possibility of SFBT and EMDR being combined to form an integrative approach that could be used with the children in this study.

Both SFBT and EMDR claim to be brief, in relation to some of the longer term traditional psychotherapies or talking therapies. In this respect the two approaches are compatible. However, the nature of how they are carried out is different. As outlined in chapter 2, EMDR, when used traditionally, focuses on a traumatic event or problem situation that is continuing to cause distress. In addition, usually the therapy is delivered in a one to one situation. The very nature of the terminology, 'delivered' emphasizes the expert–client relationship involved in this process. Whereas, in SFBT the aim of the approach is that the client and the therapist work together in co-constructing the solution.

Despite the differences between SFBT and EMDR as outlined in the previous section, it seemed to me that, on a surface level at least, there were considerable similarities between the two therapies. Some of the tools used could be said to tap into similar processes. For example, both approaches used a form of scaling as a measurement to tap into the client's subjective view of where he is in relation to a situation. In this sense, although EMDR appeared to be located in a medical model, in practice the approach relied on subjective, rather than objective measures.

3.8 The Proposed Thesis

In my practice as an educational psychologist I had found that children responded to the techniques and therapeutic tools involved in SFBT. As stated in chapter 1, I had already used some of these techniques with children to help them to engage before using EMDR in a more formal way. The feedback from these children had been positive. This had encouraged me to consider combining the two therapies in my proposed thesis. A plan began to emerge as I considered the above. The questioning techniques from SFBT could be used to engage the children in a therapeutic process, the scaling tools seemed to offer an open-ended measure that I could use with individual children within a group context and the miracle question seemed to be a way of engaging the children in envisioning a more positive future. I planned to use some of the techniques from SFBT to engage the children in the therapeutic process. My intention was to use these elements from SFBT to help the children to construct a more positive future. Once the children visualized this more positive image my proposed method was to use bilateral stimulation in the form of tapping from EMDR therapy in order to deepen positive beliefs or feelings in the children. In summary then, my aim was to use elements from EMDR to strengthen positive resources in a similar way to the resource installation phase of EMDR therapy within a framework drawing on SFBT. In terms of epistemology and conflicting theoretical approaches, it seemed to me that they were compatible if developed in an integrative way that drew on aspects of both therapies. In particular, I saw

the use of the development in EMDR of Resource Development and Installation Leeds (1998) as a way forward (see chapter 2, section 2).

Children do not always readily respond or engage in therapy which could be effective in helping them to progress. The basis of the proposed thesis posits that a therapeutic approach using EMDR within a solution focused brief therapy framework may help a child to access and engage more easily in the therapeutic process of EMDR.

There are elements of similarity in the two approaches and although differences have been identified, I am of the view that the two approaches could be compatible if constructed in a manner where one approach complements the other. SFBT could be useful in providing a more concrete framework to engage a child in the therapeutic process. Also, SFBT could provide the structure for the combined therapy. Aspects from both SFBT and EMDR could be used to help identify and enhance strengths, positives and successful coping strategies. EMDR could be useful in installing positive resources at a deeper level.

This chapter has examined how EMDR and SFBT are used traditionally. The similarities and the differences in the two therapies have been examined and I have described the elements chosen from each approach to contribute to my own therapeutic intervention.

Signposting to chapters 4 and 5

The next chapter will discuss the methodology that I chose to answer the research questions posed and the rationale for this. The method is contained in chapter 5 which looks at practical implications in respect of the delivery of the intervention.

Chapter 4 Methodology

In this chapter I will consider the approaches used and the particular model adopted to answer the research questions posed:

Main research questions

1. How do children experience a process which combines therapeutic approaches from the two distinct theoretical backgrounds of SFBT and EMDR?

    Subsidiary questions

    i. Are the children able to identify aspects that they found helpful from either of the therapies?

    ii. Do the children use any of the skills that they have learned during the sessions outside of the therapy sessions?

    iii. Do they combine any techniques from the two backgrounds?

    iv. Is there any evidence that the therapy made a difference?

2. How does the therapist/facilitator experience this process?

The appropriateness of a qualitative paradigm will be discussed, followed by consideration of the potential value of the chosen model in particular. I also provide a rationale for the methodology and methods selected for this research.

Possible alternative approaches are discussed and the methodology is considered in relation to earlier research carried out in this area. The chapter will conclude by providing details of the method of data collection used in this study.

4.1 Choice of methodology

A qualitative methodology was selected for this study. The reasons for this choice of methodology are summarised below.

Firstly, as mentioned above, the research literature on SFBT and EMDR documents a preponderance of research conducted in a quantitative method. I wanted to explore the children's experiences of my integrated approach which drew on these two therapies to add a further dimension to the existing literature within these two therapeutic approaches.

Secondly, qualitative methodology provides the exploratory framework considered to best accommodate and embrace the social constructionist stance, reportedly taken by SFBT (Gergen, 1999, Rees 2005). The purpose of the study was to gain an understanding of the views and feelings of the participants and to explore my own experiences as the facilitator of this. This required a method which would capture rich data from a depth of engagement with the children.

Thirdly, my research was located in professional practice of educational psychology. I wanted to select a methodology which would reflect the applied nature of my work as a psychologist.

4.2 Research aims

The research set out to study the experiences of a group of children during and after they had participated in a group process which combined two different therapeutic approaches: Solution Focused Brief Therapy (SFBT) and Eye Movement Desensitisation and Reprocessing (EMDR). A further aim of the research was to explore the process from my own perspective as the facilitator of the intervention.

4.3 Context of the study: What was involved?

The research involved the development of a programme to be delivered to a group of children on a weekly basis for six weeks within a school setting. Sharry (2001) points to the growing body of research to suggest the effectiveness of solution-focused group-work as a therapeutic intervention (Newsome, 2005; Schorr, 1997; Springer *et al.* 2000). The context for the delivery of the therapy was a group setting in a primary school. The research comprised an intervention based on a series of therapeutic sessions within a group context. The framework of this intervention was planned in advance and the detail modified and refined during the process on the basis of feedback from the participants and from my own observations as researcher. The participants

in the study were a group of five primary aged children at stages 5, 6 and 7 of the Scottish Primary education system (aged between 9 and 11years).

4.3.1 How does the work fit within the context of an educational psychologist in Scotland?

The duties of educational psychologists are defined in statute in section 4 of the Education (Scotland) Act 1980 which states that it is the duty of education authorities to provide a regional or islands authority psychological service in clinics or elsewhere and that the functions of that service shall include:

(a) the study of children with special educational needs;
(b) the giving of advice to parents and teachers as to appropriate methods of education for such children;
(c) in suitable cases provision for the special educational needs of such children;
(d) the giving of advice to a local authority within the meaning of the Social Work (Scotland) Act 1968 regarding the assessments of the needs of any child for the purposes of any of the provisions of that or any other enactment.

Whilst these statutory duties remain, the role of the educational psychologist has undergone many changes in the manner in which these duties are carried out. A review of the provision of educational psychology services in Scotland was carried out focusing on issues impacting on the supply and demand of educational psychologists and examining the structure and delivery of

educational psychology services across Scotland (Scottish Executive, 2002). Currently performance indicators for education authority psychological services have defined three levels of work: the level of the individual child or family, the level of the school or establishment, and the level of the local authority (Scottish Executive, 2002). Educational psychologists in Scotland have five core functions in relation to each of these levels: consultation, assessment, intervention, training and research (appendix 1). This current study fits within two of these functions of my role as a practising educational psychologist, research and intervention. At times within this thesis I will refer to both psychologist and therapist. This is to emphasise the therapeutic role that an educational psychologist can sometimes fulfil within interventions such as the one in this study. I also use the term therapist to highlight the fact that this work could be carried out by a professional trained in EMDR who is not necessarily a psychologist.

4.3.2 Context summary

The context for the research was the 'real world' of the school (Robson, 2002). The investigation was located in professional practice. Fox, Martin and Green (2007) make the point that practitioner researchers hold a unique position in the research process. These writers go on to point out that the practitioner researcher approaches research and embeds it within practice in ways that an academic researcher cannot. My own position was one of an educational psychologist working in an authority psychological service in Scotland. My

reporting would be oriented towards professional peers. I agree with the view that fundamentally there is a synergy between research and practice for the practitioner researcher in that practitioners engaged in research are more successful practitioners and researchers engaged in practice are more successful researchers (Fox, Martin & Green, 2007). My position was researcher and participant. I participated and was involved in the interactions with the children during the sessions. In that sense I contributed to and was part of the process. Certainly, I was examining the process and exploring the children's experiences. I acknowledge that, in the purist sense, I was not an impartial observer. It could be argued that I held a position of power in the process. However, I had developed my method as far as possible in line with a social constructionist stance. I endeavoured to hold to this position where possible and be part of the co-construction with the children.

4.4 Nature and type of research design

This next section will consider the design of the research and my rationale for choosing the approach. A qualitative methodology was selected for this study. The reasons for this choice of methodology are summarised below. They are then described more fully in the following section of this chapter.

4.4.1 Influences on the design and methodology

The aim of the study and my personal interest has influenced the design and methodology chosen. The aim of the study, as described earlier in this chapter,

was to reveal the children's experiences of engaging with the process, the nature of the experience and the impact of the combined therapy from their perspective. An additional aim was to examine my own experience as therapist and facilitator of the process. The methodology chosen reflects my personal interest. I am interested in the subjective experiences of the children in this study and my own experiences within the process. The methodology that I have chosen to answer the research questions posed at the beginning of my research reflects a phenomenological perspective. Interpretative phenomenological analysis (IPA) is interested in the subjective experiences of the participant (Smith, 2003). This is described more fully in chapter 6. My research is designed to investigate the individual children's perceptions and the meaning they give to these experiences. I acknowledge that I bring to the study my own past experiences (see chapter 1) and the specific subjective meanings, conscious and unconscious, that I bring to it.

The following section provides a rationale for choosing the approach that was adopted. Possible alternative approaches are discussed and the methodology is considered in relation to earlier research carried out in this area as reviewed in chapter 2.

4.4.2 Choosing a suitable approach to explore the questions posed

Cook and Campbell (1979) make the point that traditionally psychologists have adopted a 'critical realist' position. This assumes an objective reality view of the

world where there are regularities which can be measured and results replicated. There has been ongoing debate within the fields of psychology and education about the appropriateness of the traditional research methods when attempting to answer some of the participatory research questions such as those posed in this research. The aim of my study was to surface experiences, my own and those of the children who took part. The questions posed sought to explore the experiences of the children who participated in the study and to reflect on my own experience of the process. A scientific epistemology that stresses the empirical objective collection of data using a hypothetico-deductive approach would not answer the two main research questions posed, both of which sought to explore experiences. The purpose of the research was concerned with the exploration of 'lived experience and participant-defined meanings' (Willig, 2001). A quantitative methodology would not enable the subjective experiences to emerge and instead may oversimplify the complexity of human experience (Langdridge, 2004). This participatory approach required a methodology which would be appropriate to investigations carried out in real world enquiry (Robson, 1997). Reason (2003) makes the point that in the primary tradition of research in psychology there is a separation of subject and object with the researcher making all of the decisions. Robson (1993) suggests that some studies in the 'real world' require flexibility in design and prosecution. In my own study a traditional quantitative methodology would not be appropriate. Fixed designs involve 'a very substantial amount of pre-specification about what you are going to do and how you are going to do it' (Robson, 2002, p.4). In contrast, in

flexible designs 'much less pre-specification takes place and the design evolves, develops and .... ''unfolds'' as the research proceeds' (Robson, 2002, p.5). The current research was designed in accordance with the principles of applied psychology. It was assumed that theories and concepts would emerge from the process and that the process itself would follow a cyclical nature which would generate the next step of the intervention strategy. This required a flexible research design.

The longer term aim of the study was to inform my own practice and possibly that of colleagues in educational psychology. The so-called 'gold standard' of randomised control trials (RCTs) would not be appropriate or relevant to this form of naturalistic research. As Frederickson (2002) points out when applied to social science interventions, the efficacy of RCT based evidence is not the only consideration (even where an RCT can be utilized). The applicability of any researched intervention in the field of social science is at least as important as effectiveness. Taylor and Burden question the appropriateness of experimental/control group designs for evaluating real-world interventions (as cited in Frederickson, 2002). They hold the view that this would be both impractical and unethical. I wanted to carry out naturalistic research which could be applied within the field of educational psychology. The approach required a flexible design. An approach which involved RCTs or comparison trials similar to the earlier EMDR studies would not have been appropriate to achieve the flexibility required in this therapeutic intervention.

Reason (2003) contrasts another inquiry tradition where there is more collaboration between the researcher and the subject. This involves a participatory perspective where all of those engaged in the inquiry process enter the process as persons bringing with them intelligence, their intentionality and their ability to reflect on experience and to enter into relations with others (Reason, 2003). The group-work would require a participatory design. The children and I would be participating and collaborating in an emerging process.

I was concerned with a process of exploration of children's experiences as they participated in the therapeutic intervention. My own presence as facilitator and therapist was part of the process and as such I required an approach that would enable me to consider this within the experience. The stance of 'insider researcher' was appropriate as I was part of the process. It would not be appropriate to apply a positivist paradigm. The setting was within a group in the context of a school. Being a member of a group and behaving as a member of a group have psychological consequences (Sherif, 1966). In the group that I was working with it was highly likely that there would be a process of interactions between the children, and between myself and the children. A quantitative methodology is more concerned with measurement and seeks to investigate causation and make predictions. This would not have been appropriate for my purpose and would have limited the information that could have been accessed. It is pertinent at this point to acknowledge that I used behavioural checklists for teachers and parents and a self evaluation checklist with the children (see

PAGE NUMBERING AS ORIGINAL

collection and analysis, and restrict control over what can emerge from the analysis through the application of predetermined categories for coding. The research methods chosen in this study included semi-structured interviews with open-ended questions. The analysis of the data did not start from predetermined categories but instead themes emerged from the data produced (see chapter 6). In this sense the research would sit within a definition of 'Big Q' qualitative research.

Allport (1962) makes the point that most research has been done within the nomothetic tradition, which emphasises pooling people to look for commonalities, rather than the idiographic tradition, which emphasises individual uniqueness. This is true to a large extent of the research on EMDR. The combined therapy used in my study included aspects of EMDR but unlike much of the earlier research into EMDR my interest was not in the search for commonalities or for cause and effect factors. Instead, my interest was in the ideographic tradition. This type of idiographic methodology provides data that is rich, descriptive and contextually situated and captures the richness and complexity of phenomena such as perceptions, experiences and attitudes (Cohen & Manion, 1994, 2008). The two approaches of EMDR and SFBT reflect differing epistemological positions. The study could have been designed to measure treatment variables or to investigate a comparison with another therapy as the earlier research into EMDR. However, the purpose of my study was to gain an understanding of the views and feelings of the participants and to

explore my own experiences as the facilitator of this creative combined approach to delivering a therapeutic intervention. Reducing the information to a quantifiable or numerical format would not ascertain the rich and illuminative data to investigate the questions posed in this thesis. A qualitative design was felt to be most appropriate as this would take into account the individual views of each of the participants and the context. The research was in the idiographic tradition emphasising the individual uniqueness of the participants. It is my contention that my work could sit side by side with previous studies to enrich and add to the current picture.

4.5 Links with the literature

This section provides a discussion of the links with the literature relevant to this study.

4.5.1 EMDR

As described in chapter 2, the literature reviewed on EMDR indicates that early studies focused mainly on adults (Shapiro, 1989; Solomon *et al.*1992). The evidence from these studies supports the view that there has been considerable empirical validation of EMDR. However, the largest body of research on EMDR has focused on the area of Trauma related problems, in particular, PTSD. The aim of these studies was to investigate the efficacy of EMDR compared to other psychological treatments or with a control group who did not receive any treatment. These aims required a scientific research paradigm. In the current

study which was developed in terms of efficacy and least intrusiveness, a similar methodology would not be appropriate to answer the questions posed where there were not clear defined problems at the start.

4.5.2 SFBT

SFBT provided a framework for the sessions. Much of the research in the SFBT literature and indeed in psychotherapy in general is in the quantitative tradition (Gingerich & Eisengart, 2000). Brown and Dowling (1998) hold the view that educational research does not necessarily begin with clearly defined and articulated problems and empirical settings. They assert that the research process itself is properly conceived of as the construction of the theoretical and empirical as increasingly coherent and systematically organised and related conceptual spaces.

The questions posed in the current research are concerned with a social constructionist position. The emphasis is on the process rather than the structure. The group sessions were designed to respond to the children's responses either within a session or at the following session. In the sessions the subjective views of the children were accepted and formed the basis of the shaping of next steps in the process. This is similar to SFBT and solution oriented approaches. The therapeutic nature of the current study required flexibility within the design method.

4.5.3 The current study in relation to a social constructionist approach

A social constructionist methodology relocates problems away from the within child deficit view of learning and functioning. Bronfenbrenner's (1979) model of the ecology of human development underlies the practice of educational psychology today. This model acknowledges that human beings don't develop in isolation but in relation to those around them, families, school, community and society. In the context of the work of an educational psychologist this could be the teachers, the curriculum and how it is presented to a child. This contextual framework surrounding the work of an educational psychologist is reflected in the legislative framework in Scotland, as described more fully in chapter 1. Educational psychologists have moved away from a medical, deficit model which perceived the problem to be within child. The model now perceives difficulties arising from the context surrounding the child. The move to see additional support needs more broadly and to remove or reduce barriers to learning is enshrined in recent legislation (The Additional Support for Learning (Education) (Scotland) Act 2004). The aim is to work with key individuals in a child's life such as the teachers and parents, to remove or reduce any barriers to learning. Children exist in contexts such as school, home and the community. However, merely adjusting the environment did not in itself appear to be sufficient for some children, at least according to the views of their teachers.

4.5.4 A Social Constructionist Perspective

SFBT is underpinned by social constructionist and constructionist stance. (see chapter 2, section 1). In SFBT the emphasis is more on processes than on structures. Constructionist psychologies hold the view that each individual perceives the world differently and from the individual's perception of the world the person then actively creates meanings from events. The 'real' world is therefore a different place for each of us (Burr, 1995). The influence of constructionist thinking means that the therapist views the therapeutic relationship as collaborative and co-constructive. The therapy in my study combined elements from SFBT and EMDR. The individual therapy sessions were planned in advance but flexibility was needed for the exact detail of the therapy to be responsive to the feedback from the children at the beginning of each session and during a session. In this sense the relationship between the children and the therapist (myself) was collaborative and co-constructive. I make the caveat here, as mentioned earlier, this collaboration is not claimed to be absolute in the light of the power differential between therapist and child. However, the influence of constructionist thinking was relevant within this dynamic process. The combined therapy was delivered in a group setting with 5 children forming part of the group. Each child experienced the event from his or her own perspective and in line with a constructionist position each child actively created meanings from these events during and after the sessions. Danziger (1997) refers to the difference in focus between 'light' and 'dark' social constructionism. In my research design the therapy involved the children

listening to the responses of the other children in the group. This fits with Danziger's view of 'light' social constructionism. In light social constructionism people construct themselves and each other during interaction rather than as a result of social forces. The children were able to overhear the contributions of their peers. In this sense each child was able to gain some appreciation of others' constructions. This is similar to Kelly's (1955) constructivist 'sociality' position which argues that everyone construes the world differently but individuals are able to gain an appreciation of another's constructions and they are able to change their own construction of the world to create new possibilities for action. The context of a group allowed these new possibilities to emerge and shape new meanings for the individual children within the group. During the therapy the individual children 'told their stories' Gergen & Gergen (1994). Through this process the other children constructed their own narratives. This is in line with a solution oriented view (O'Hanlon & Weiner-Davis, 1989).

Constructionism sees the individual as having an active role in the creation of their experience. The view is that each person perceives the world differently and creates his/her own meaning of the events. From this perspective the belief is that the way that we acquire and share knowledge is related to our experiences and in particular to the interpretation we ascribe to these experiences. In this view, truth and meaning are made reality by encounters in the real world and by the interpretation applied to these experiences by the

person. Kelly (1955) in his personal construct psychology argues that we each develop a set of dimensions of meaning which he calls constructs and that we perceive the world in relation to this set of constructs. The children in my study had been described by their teachers and parents as quiet, shy, withdrawn and/or anxious. The semi-structured interviews with the children seemed to confirm this (see chapter 6). If this were the case, then following Kelly's view, these children would perceive the world in relation to a negative view of themselves. Kelly's philosophy of 'constructive alternativism' suggests that even the most obvious occurrences of everyday life might appear utterly transformed if we were inventive enough to construe them differently (Kelly, 1986). My own position as researcher, as outlined in chapter 1, supports this view. My intervention was devised with this in mind.

This view opposes the essentialism of much of traditional psychology Burr (1995). The view of positivism and empiricism in traditional science with assumptions that the nature of the world can be revealed by observation would not be appropriate for a participatory exploration of the experiences of the children in this study. Nor would it be suitable to explore my own perspective as therapist and facilitator of the process. The approach chosen was one that reflected my own position as researcher and participant in the group work. 'Professional-as-scientist' outsider research Barlow (1984) would not have been appropriate to explore my own experiences of the process or to answer the research question: how does the therapist/facilitator experience the process?

4.6 Ethical considerations

This research was carried out within my professional competence. I am a registered practitioner with the Health Professions Council and a chartered psychologist with my professional body, the British Psychological Society. I am also accredited by the EMDR UK & Ireland as an EMDR Practitioner and also as an EMDR Consultant in EMDR. The research adhered to the British Psychological Society Code of Ethics and Conduct (March 2006). Measures were taken to respect the children's dignity and rights. Permission was sought from the children's parents for inclusion in the work (appendix 2). Parents were requested to ask the children if they wished to be involved. When I met the children I also provided details of the group-work (verbally) and checked if they still wanted to be part of the study. I also explained that they could withdraw at any time (appendix 3). Data was encrypted and password protected. Audio and video recorded material will be destroyed once the research is completed.

4.7 Summary

My research was located in the professional practice of educational psychology. This participatory approach required a methodology which would be appropriate to investigations carried out in real world enquiry. The purpose of this study was to gain an understanding of the views and feelings of the participants and to explore my own experiences as the therapist and facilitator of the group experience using EMDR and SFBT. The framework of solution

focused brief therapy was used to support Eye Movement Desensitization and Reprocessing. The aim therefore was to reveal the children's accounts/stories of engaging with the process, the nature of the experience and the impact of the combined therapy. The intervention was based on a therapeutic process. There was a need to personalise the therapy to the individuals within a group setting. This was important from an ethical point of view. It was also essential as the target for improvement for each child had been personally chosen by them and as such the process was operating with different goals for each child within the group setting. A flexible research design was required. The methodology chosen to answer the research questions posed reflects a phenomenological perspective. A qualitative methodology provided the exploratory framework considered to best accommodate and embrace the social constructionist stance adopted in this research.

Signposting to Chapter 5

The following chapter describes the development of the research from theory to practice. The method of data collection which is consistent with the above methodology will be outlined. The chapter will then provide a description of what happened during each session.

Chapter 5 Method: The Therapeutic Intervention from Theory to Practice

In earlier chapters I described the therapeutic orientation upon which my research study is based. In this current chapter I will describe the move from theory to practice. The practical detail of the process is described. I will provide a description of the stages involved in the process. This includes the preparation phase when the intervention was discussed with school staff, the conceptualisation of the intervention and the data collection phase after the group sessions had taken place. I will provide the reader with the detail of what was involved in each of group sessions with the children involved in this study. I have chosen to include this level of detail in this chapter in an attempt to bring the sessions to life and to reflect the experiential approach of this research study. The sessions were lively and dynamic. Hopefully something of the flavour of these sessions will be portrayed. The chapter concludes with my reflections on my experience of the process.

5.1 Introduction to Method

The rationale for the method of data collection was consistent with a qualitative research paradigm. I collected data before, during and after the group-work sessions. I have included in the appendices, data from one child (child 2) as an exemplar of the data gathered in order to provide some continuity for the reader and to exemplify the process of analysis. In the following section I will describe the process at each of these stages.

5.1.1 Caveat: a word of introduction

By way of introduction in this chapter I will begin by clarifying my use of rating scales in this study. As described earlier this research is in the social constructionist tradition. Behavioural rating scales derive from a positivist tradition and suggest that something exists that can be measured, rather than socially constructed. The epistemology of the scales contrasts with the epistemology in which I have located my study. However, the scales were not scored numerically. Instead, I used the responses qualitatively to provide me with an indication of the perceptions and evaluative beliefs of the children, the teachers and the parents. Other methods may have been used as an alternative but these appealed for a number of reasons. Firstly, as they were easy to administer teachers were able to complete them without too much disruption to their teaching schedules. Secondly, this study was designed as early intervention. I, therefore, wanted an indicator that would assist me in ruling out any child who appeared to have a high level of need which might require an individual and more intensive intervention. Thirdly, the study was designed to focus on strengths. The rating scales would provide an indication of perceived strengths and would possibly provide me with a sense of each child.

The checklists were not subjected to a process of statistical analysis. Instead, I examined the behavioural indicators qualitatively to provide me with any evidence to support the teachers' initial views. The information was also used to

exclude any child who appeared to have a more serious problem and who was already involved with another professional or who would require individual input by a support service such as my own or from a medical service such as the Child and Adolescent Mental Health Service. The information gathered from the children's parents added another dimension and provided me with some insight into the child outside of school.

5.2 Stages in the process

The following section will document the stages in the process. It will include the initial preparation and planning phase, the execution of the group-work and the follow-up. This is presented below in figure 1.

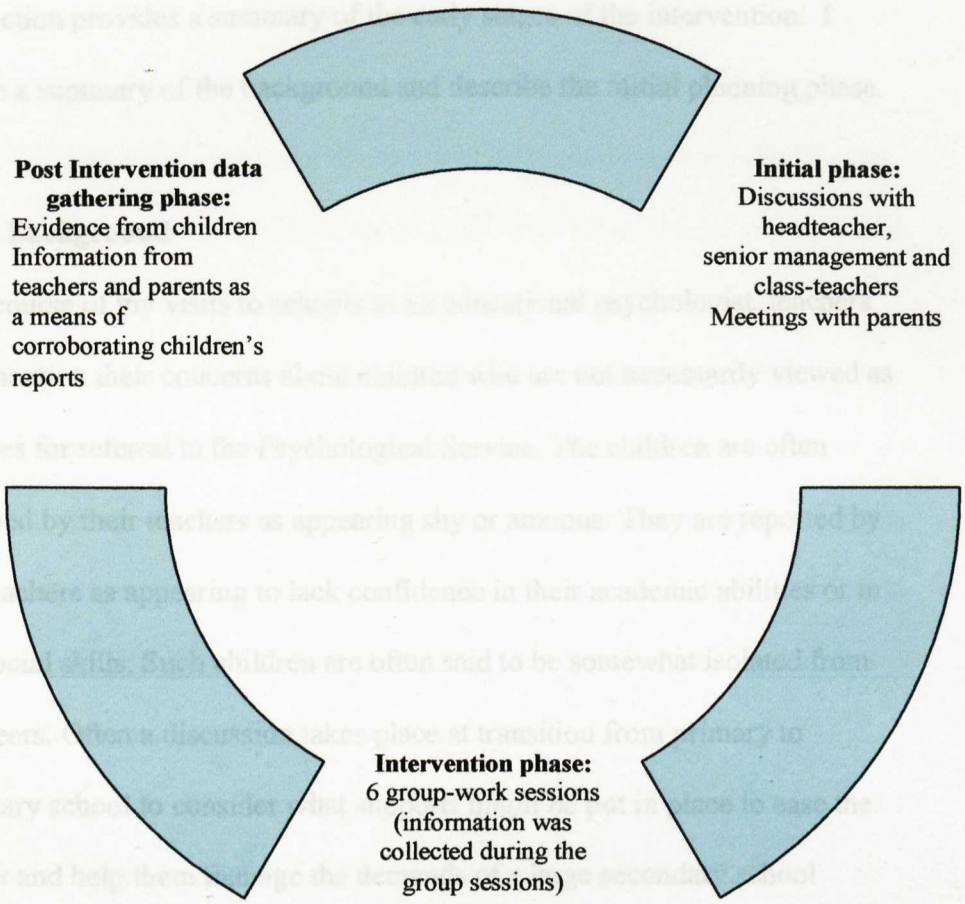


Figure 1: Stages in the process

5.2.1 Stage 1: Initial phase

This section provides a summary of the early stages of the intervention. I provide a summary of the background and describe the initial planning phase.

5.2.1.1 Background

In the course of my visits to schools as an educational psychologist, teachers often mention their concerns about children who are not necessarily viewed as priorities for referral to the Psychological Service. The children are often described by their teachers as appearing shy or anxious. They are reported by their teachers as appearing to lack confidence in their academic abilities or in their social skills. Such children are often said to be somewhat isolated from their peers. Often a discussion takes place at transition from primary to secondary school to consider what supports might be put in place to ease the transfer and help them manage the demands of a large secondary school environment. Despite these arrangements my experience when working in High schools is that some of the children continue to struggle with the demands of school. They respond to the stress of their situation either by withdrawing even further, for example by non-attendance at school, or by exhibiting challenging behaviour. My intervention was an attempt to address some of these issues at an early stage. The intervention used positive resources to encourage the children to cope better with school.

5. 2.1.2 Planning the intervention

i) This particular school was chosen as I was the educational psychologist who visited the school regularly. As the study involved me as a participant in the group I felt that it was important that the context chosen was one where I was not seen as a complete outsider. It was a fairly large school in the authority and therefore it was likely that enough children could be identified to make the study feasible. Initial discussion took place with the headteacher of the primary school. The aim of this first meeting was to explain the purpose and general detail of the proposed intervention and to seek permission from the headteacher to carry this out within the school. Broad criteria were identified for children to be considered for the intervention (teachers are concerned as child is unusually quiet, appears to lack confidence, seems withdrawn, worried or anxious). Children who displayed challenging behaviour were not included. These criteria would be used by class teachers initially to identify possible children. In discussion with the headteacher it was decided that children from the upper primary should be considered. It was hoped that those children could benefit from the intervention prior to their transfer to secondary school. The headteacher was keen on the project and agreed to discuss it further with the school senior management team and class teachers in order to identify potential participants for the group work.

ii) I met with the senior management team and with the class teachers who had identified children for consideration for the intervention. The purpose of the

intervention was explained to these members of staff and the teachers provided a verbal description of the children's difficulties as perceived by their teachers. The headteacher had previously spoken to class teachers of the upper primary seeking suggestions of names of children who fitted the broad criteria. 5 children, 3 boys and 2 girls, were identified through this process. The children all came from different classes. Initially 7 children had been suggested but one child had complex issues and was already involved with a number of professionals. I decided to exclude this child from the group work as it was possible that the effect of any other involvements outside the sessions might contaminate the results of my research and therefore it would not be possible to determine the effect of the therapeutic intervention on the child. The other child lived in a neighbouring authority. The psychological service where I work does not do direct work with children who live outside the local area. Both of these children were therefore excluded from the research. As no other children had been identified by the school staff only 5 children were included in the work. Although a small number of children this was in fact a positive factor as the therapeutic work required me to be sensitive to the safety and individual needs of each child during the therapy. This would have been more difficult to achieve in a large group.

iii) The teachers were then provided with the Self-Esteem Indicator: Primary and the Behavioural Indicator of Self-Esteem (BIOS) to complete for each child. The Self-Esteem Indicator Primary is a tool designed for developmental

purposes by Morris (2002). The checklist purports to give a basic indication of the level of a child's self-esteem. It is also said to provide an indication of a child's weakest and strongest components of self-esteem. The Behavioural Indicator of Self-Esteem is an instrument designed by Burnett (1998) to provide teachers and Special Educational Needs Co-ordinators (SENCOs) with a means of observing and recording the frequency of behaviours indicative of self-esteem. The checklist consists of 13 statements relating to a child's observed behaviour. All checklists were returned.

iv) The headteacher contacted the parents of the identified children by telephone to explain about the proposed intervention and to inform the parents why their child had been identified by the teacher. The parents were asked for their permission for the child to be included in the study. Letters were sent by the headteacher offering an individual meeting with me. The meetings were arranged in the school on a Parents' evening. The focus of each meeting was to explain the purpose of the research and to provide a description of the intervention. The parents of 3 of the 5 children met with me (Both parents attended for one of the children). Parents were interviewed and information was provided about the proposed intervention. They were told that I was involved in research and that the findings would be written up for that purpose. Parents were also told that I would contact them again at the end of the group work to interview them again. The parents provided some background information on their children. They also indicated any concerns that they had about their

children. Parents were asked to let their child know about the proposed group-work and ask the child if he or she wanted to be involved. The parents (2) who did not attend the parents' evening were contacted by me by telephone and similar information about the proposed intervention was provided to them. They also provided information on their children and identified any concerns they had. I wrote to each child's parents confirming what I had told them.

All parents completed the Revised Rutter Parent Scale for School-Age Children (1999b). All 5 checklists were returned. The revised Rutter Parent Scale was used as a subjective measure to ascertain the parents' views on their child. The scale offers a choice of 'does not apply', 'applies somewhat' and 'certainly applies'. The parents rated each statement on this scale according to how they viewed their child on the specific items. The responses were used in a qualitative way to provide me with profile of a child and to rule out any child where there was a serious concern.

The checklists were used as a tool to gain qualitative information to assist me in ruling children in or out of the group-work depending on any underlying serious concerns. This intervention was aimed at children who appeared to be having some difficulty in school. This was not planned as an intensive intervention focusing on more extreme problems. The aim of the study was to devise an intervention which might make a difference to the group of children who were often omitted when schools had to choose who to refer to specialist services,

despite their teachers having concerns about them. I was particularly interested in the children who appeared shy and/or anxious. These children were often described by their teachers as not having much confidence or appearing to have low self-esteem.

v) Each child completed the Burnett Self Scale (BSS) (1994) as a self report checklist at the first meeting of the group. The choices on this checklist are 'never', seldom', 'sometimes', often' and 'always'. I used these as a means of engaging and focusing the children at the first meeting. I was aware that talking may not have been easy for this group of children who had been identified as shy or anxious. This activity did not require them to talk. The checklists also provided me with information on each child's perception of him or herself. The information helped me in creating and planning the detail of the sessions. Table 1 provides a summary of the data collected prior to the intervention as a means of identifying children for the group-work and to help guide the planning of the therapy.

Completed by	Number	Name of Instrument
Teachers	5	Self-Esteem Indicator: Primary (nferNelson) (appendix 4). Behavioural Indicators of Self-Esteem (BIOS) (nferNelson) (appendix 5).
Parents	5	Revised Rutter Parent Scale for School-Age Children (nferNelson) (appendix 6).
Children	5	Burnett Self Scale (BSS) (nferNelson) (appendix 7).

Table 1: data collected prior to group-work

5.2.2 Stage 2: The therapeutic intervention

This section begins by re-stating the context and aims of this study. This is followed by a description of the content of the sessions and a summary of what happened during each session.

5.2.2.1 Context and aims

The research comprised an intervention based on a series of therapeutic sessions within a group context. The framework of this intervention was planned in advance and the detail modified and refined on the basis of feedback from the participants and from my own observations as researcher during the process. The participants in the study were a group of five primary school children at stages 5, 6 and 7 of the Scottish Primary education system. (aged 9 to 11). The

intervention took place between November and January and consisted of 6 sessions.

The general aim of this research was to investigate this combined therapeutic process in the context of the Scottish Education System and in particular within an applied psychology perspective. The research set out to study the experiences of a group of children during and after they participated in a group process which combined two different therapeutic processes: Eye Movement Desensitization and Reprocessing (EMDR) and Solution Focused Brief Therapy (SFBT). A further aim of the research was to explore the process from my own perspective as the facilitator of the intervention. The main research questions were:

1. How do children experience a process which combines therapeutic approaches from the two distinct theoretical backgrounds of SFBT and EMDR?

Subsidiary questions

i. Are the children able to identify aspects that they found useful from either of the therapies?

ii. Do the children use any of the skills that they have learned during the sessions outside of the therapy sessions?

iii. Do they combine any techniques from the two backgrounds?

iv. Is there any evidence that the therapy made a difference?

2. How does the therapist/facilitator experience this process?

5.2.2.2 Planning the detail of the therapeutic intervention

The intervention was based on a process which combined aspects of SFBT with EMDR. The rationale was that the solution focused techniques would be used as a framework to help the children to focus on their own individual aspirations, whilst aspects from EMDR would be used to strengthen positive beliefs.

The approach drew the following techniques from the theoretical background of SFBT:

Solution oriented questioning (What's been happening that's been different?).

Scaling questions (On a scale of 1 to 10 where 1 is the worse it has been and 10 is the best it can be, where are you now? What needs to happen for you to move one point up the scale?).

The miracle question (If a miracle were to happen when you are asleep tonight and you knew nothing about this, but when you wake up tomorrow things are better, what would you notice that was different?).

Imagery and future possibilities (Imagine a time in the future when you are doing well at what you have chosen to work on .... notice what is happening, how you look, how you are feeling as you are doing well. Now imagine that you have this skill. Or, think of someone else, real or a character in a book or film

who displayed that skill/resource. Now imagine that person is with you helping you).

The aspects of EMDR used included the following:
Positive cognition (What would you like to believe about yourself?).
Bilateral stimulation (Alternating bilateral hand taps).
The butterfly hug (The children were taught to tap their own shoulders - right hand across left shoulder, left hand across right shoulder).
Future orientation in time (Think of a time when you were able to ..... Now beam yourself forward into the future with the resources that you need and see yourself doing well, experience being proud of yourself). This was based on the child's positive cognition. Bilateral stimulation (taps) was then used to strengthen this.

Using the combination of SFBT and EMDR enabled me to individualise the therapy within a group setting. The work was also individualised through a feedback process at the beginning and end of each session. A framework for the content of each session was planned in advance. However, the exact detail of each of these sessions was based on the feedback from the children and from my own observations during the sessions. In addition, sessions 2 to 6 were audio recorded. Session1 was not recorded as I wanted to establish rapport with the children and also seek their permission to record future sessions. Sessions 3 to 6 were video recorded as an aid to the planning of future sessions. Sessions 1 and

2 were not video recorded as I wanted to establish the group and aim for natural responses from the children before introducing the camera which may have made them uncomfortable. The video recordings provided a more objective record of the children's behaviour and responses during the intervention sessions. The purpose of this was to have a record of the children's behaviour and responses during the intervention as a means of examining the sessions in more detail to check if I had missed anything during the group-work and to keep a check on the progress for the individual children. I was aware that this was a complex process and wanted a means of ensuring the therapeutic safety of each child within the group setting. I also made field-notes at each session as an aide-memoir. These included my thoughts and reflections on the process and acted as a prompt to plan or adjust the content of the following session.

5.2.2.3 What happened in the group-work sessions?

This section gives a description of the content of each session. This level of detail is included in this chapter to provide the reader with some practical insight into the process. It is also included for anyone wishing to replicate the intervention, with the proviso that although the aims and general framework of the sessions can be planned in advance, flexibility will be required in the detailed planning of each session based on feedback from participants. Aims of each session are provided in appendix 8. My personal reflections on each of the sessions, based on field-notes taken at the time and immediately following each session, are contained in appendix 9.

Session 1 in practice: 19th November 2004 - length of session 60 minutes

The 5 children who had been identified met with me as a group in the school resource room. I introduced myself and explained a little about my job as an educational psychologist. Each child introduced him or herself. The parents had been asked to explain about the work and ask their child if he or she would like to take part. In the first session I again explained the purpose of the group work to the children to ensure that they were clear about the purpose. I explained that the work was to look at an approach to see if it could be helpful to them and also to help other children in the future. The children were also told that I would record some of the sessions and that I would meet them individually after the group work was completed to ask them some questions about their experiences. The children were asked again if they would like to take part. All children agreed and gave their permission for the work to be used as research. As a means of enabling the children to share some of their details each child drew a picture of something he or she enjoyed doing or something they were good at to share with myself and the group. Each child completed the Burnett Self Scale (BSS). The children were told that I would take these away and look at them to help me to plan the work that we would be doing.

I was an adult (and to some extent a stranger) and the meeting was taking place in school. It was likely that these factors would skew the balance of power in any relationship. I wanted to establish from an early stage that the children

would be given a voice (Davie, Upton and Varma, 1996; The United Nations Convention on the Rights of the Child (article 12), 1989). The children discussed a future date taking cognisance of subjects that they did not want to miss. Although this led to my having to juggle my diary, I felt that it was a valuable first step on the road to co-operation and collaboration.

Session 2 in practice: 1st December 2004 - length of session 60 minutes

All 5 children attended this session.

What was noticeable at this session was the difference in their demeanour and apparent engagement. For example, one of the boys was quiet and appeared tired. I wondered initially if he did not wish to continue but he took part in the tasks. When I checked he told me that he had been late in bed the previous night. Another boy was very keen to participate and had brought a photograph of his pet dog to share with the group following the discussion at the previous session. Another boy appeared involved but quietly reflective before contributing to any discussion. The girl who had been described by her teacher as having learning difficulties and often refusing to speak or do any work was very chatty. The other girl participated well in the process. The children chose something that they would like to be better at. This choice was left entirely open to them. Two children chose maths, two chose spelling and one chose basketball. They were asked to say where they were at that time on a scale of 1 to 10 (where '1 is I am not very good and 10 is the best I could be'). The children were then asked to

remember a time when they had done well at something (not the desired goal). Each child was able to do this and briefly described their situation. The purpose of this feedback was done as a check that the situation that they had chosen was appropriate and safe for me to work on. I then asked the children to imagine themselves in the situation where they were doing well. The image was then enlarged using visual, audio, and kinaesthetic suggestions to guide the imagery. Feedback was received from each child focusing on how they felt during this positive experience.

Directions were given for the following activities:

Standing in a circle around the table facing the person in front of you, think of a time you did something well – make it bigger, brighter (imagery). Now march round the table imagining doing well, feeling good, and feeling proud of yourself'. (EMDR – bilateral stimulation). The children were then taught the 'butterfly hug' (EMDR) and practised this while experiencing the positive emotion based on the above activity. Now imagine yourself being presented with a certificate for doing well at something. See yourself the way you want to be, notice what you look like, what you are wearing, who is there, any sounds, colours, movement, how you are feeling when you are doing well. (Imagery). Now tap the shoulders of the person in front of you in the circle (EMDR).

The session closed with a discussion of the experiences that the individual children had undergone. The words that the children said during the feedback would be used as a positive cognition in a future session, for example "well done", "I can do it"," I am confident".

Session 3 in practice: 8th December 2004 - length of session 30 minutes

Only 2 children attended this session. One child was ill and the other was on holiday. Another child was in hospital for pre-planned dental treatment.

The session began with feedback from the previous session to check what the children had remembered from the previous session that they had attended. Further practice of the butterfly hug took place focusing again on the positive emotions from the self confidence imagery from the previous session. SFBT scaling questions were used: Where are you now on the thing that you said last time that you wanted to be better at? (i.e. spelling or maths). What is it you are doing to be at that number on your scale? The children drew a picture based on the imagery at the previous session. They then wrote the words that went with that picture for them, e.g. "I'm trying my best. I can do my best"; "I'm really good at maths at all times".

Session 4 in practice: 15th December 2004 - length of session 30 minutes

4 children attended this session. One child was absent due to illness.

Feedback - What do you remember from the last session attended? A SFBT scaling question was used to assess where the children perceived themselves to be now on their chosen topic that they had identified at the beginning as something they wanted to work on to become better at it. The children reported measures between 8 and 9 ½ on a scale of 1 to 10.

Each child wrote a sentence about a time they felt confident. They then shared this positive experience with the group. Discussion centred around how that felt. Imagery of this experience or from the time when they had imagined being presented with the certificate was chosen to be used to strengthen the positive feelings linked to the experience. The words that went with the image were repeated silently while tapping on the table (EMDR). I explained to the children that they could say their own chosen words out loud or to themselves, (e.g., 'Well done' when you are pleased with something you have done or when you have tried hard at something).

The session finished with the children doing the butterfly hug as they said the words that they had chosen. The butterfly hug was used in this way to reinforce the positive cognition. Homework task – If you like you can practice saying your words paired with the butterfly hug whenever you wish.

Session 5 in practice: 12th January 2005 - length of session 45 minutes

All 5 children attended this session.

General discussion took place to share positive experiences from Christmas holidays. Feedback from previous session was elicited. What has been better? What has been different? (SFBT).

'Strength Cards for Kids' Deal (2003) were used as a resource to stimulate discussion. The cards each depicted an animal with a statement pertaining to that animal. I had previously chosen cards that seemed relevant to one or more of the children, for example, ' I can change', 'I will try new things', 'I am very good at some things'. This led to what is known in EMDR as the psycho-educational phase (EMDR). This is where, at an appropriate time, a client is presented with some new information to help them to make sense of their situation. This phase in the group-work involved me telling the children information, for example, about everyone being different, and about valuing our own particular qualities and strengths, just like the animals portrayed in the cards.

This was followed by a writing activity to identify strengths and positives in another member of the group. After feedback and discussion of the experiences the children were taught affirmations based on their chosen card. These words that the children chose for themselves were used as positive cognitions and installed using bilateral stimulation through tapping (EMDR) the shoulders of

child in front as they marched round the room in a circle. A homework task was to practice their individual affirmation.

Session 6 in practice: 19th January 2005 - length of session 45 minutes

All 5 children attended this session.

Final feedback: SFBT questions -What has been happening that has been better? What has been different?

The children then rated their positive cognition after I checked that their original positive cognitions were still appropriate (EMDR).

The miracle question was used to expand the miracle (SFBT).

Installing the 'miracle' (as a positive cognition) was done using bilateral stimulation through tapping (EMDR). This was achieved by the children standing in a straight line while each child tapped the shoulders of the child in front. I stood at the back of the line tapping the shoulders of the last child.

See yourself in a few weeks time the way you want to be. (This was similar to a technique used in EMDR called the future orientation in time). Bilateral stimulation (EMDR) using tapping continued.

The positive cognition was affirmed with bilateral stimulation using tapping (EMDR).

The children provided feedback to myself and the other children on their experiences during this activity.

Closure of the final group-work session

i. Each child was given a journal to take home to keep personal notes, if they wished, of what had been helpful.

ii. The children were told that they could use using the 'butterfly hug' with their personal word, phrase or sentence whenever they wished (positive cognition).

5.2.2.4 Data gathered during the group-work sessions

Table 2 summarises the method of data collection used during the group-work phase.

What	When
Field-notes	During and immediately after each session
Audio recordings	During sessions 2 to 6
Video recordings	During sessions 3 to 6

Table 2: data collected during the group-work sessions

5.2.2.5 Stage 3 Data gathering: post intervention

I met with each child individually to complete a semi-structured interview (appendix 10). This took place 2 months after session 6. The interviews were audio recorded and later transcribed. (This will be discussed more fully in chapter 6).

Teachers were asked to complete the same checklists as they had previously completed, the Self-Esteem Indicator: Primary and the Behavioural Indicators of Self-Esteem. Also, I met with each teacher individually 4 to 5 months after the last session with the children to carry out an interview consisting of open-ended questions.

I also interviewed parents asking them open-ended questions 5 months after the final session with the children. During this interview parents were also asked to re-rate any items that they had noted as a concern on their original checklist.

5.3 Reflections

In this section I will reflect on my experiences during the different parts of the process. I will highlight some of the areas that presented issues for me and try to explain how I dealt with these.

5.3.1 Setting up the group-work

This initial setting-up process took a considerable time. This was necessary to ensure that the therapy was appropriate for the children. It also provided me with the opportunity to involve the school management staff in some of the decision making. Although a necessary and ethical part of the process I was disappointed that the work would not be able to commence when planned. This led to a knock-on effect of having a gap in the therapeutic process over the Christmas holidays. I wondered what the effect of this gap in the therapy would mean when we met again and whether it would have a detrimental effect on the children's progress and indeed on the research.

5.3.2 Thinking on my feet

As mentioned earlier, this was not a static pre-planned formulaic set of procedures. The general structure of the sessions was planned but as with most therapies this was an interactive dynamic process with the therapist responding to the client within the process. This requirement to respond therapeutically to each individual child within a group setting meant that I had to reflect and respond creatively during each session. Although at times this was quite a challenging experience, I found this part of the process stimulating and exciting as a therapist. It led me to draw on my previous training as a psychotherapist and it enabled me to incorporate other techniques from my therapy 'toolbox' such as Neuro-Linguistic Programming (NLP) (Andreas & Andreas, 1989; Bandler & Grinder, 1975).

The decision to include the girl who rarely communicated with her teacher and who often did not do her class tasks meant that I had to find a way to ensure she was fully included. Her pace with written work was slower than the other children in the group. This meant that I had to facilitate the process in a way that kept her in tune with it but did not bore the other children. This was a challenge but in fact a very worthwhile one. This girl surprised me by joining in discussions and sharing relevant experiences. I did not witness any of the refusal to speak that her teacher had evidenced in the classroom. Certainly her pace for any written activities was slower than the rest. She enjoyed drawing and would spend a lot of time colouring in. I had to be creative in order to move the therapy process on without her feeling that she had not completed a drawing to her satisfaction. Despite these challenges for me as a therapist and as a facilitator I was pleasantly surprised at how much this girl had got from being part of this process. There were signs of this during the feedback sessions. This was confirmed by her teacher half-way through the intervention when she told me with delight that the girl was talking more in class and that she was keen to do her school work. The child's responses to the semi-structured interview added further weight to this outcome.

Another difficult issue was when a child was absent. Over the course of the group work one child had to go into hospital for some dental work and as expected over any winter period a couple of the children were off school due to

illnesses. My dilemma when this happened was whether to postpone the meeting or to continue with the children who were there. When working in a one to one situation with an individual this is not a problem. The therapy session is rearranged and work continues when that individual returns. I did not want to lose the momentum for the children who were at school but on the other hand I was unsure if by continuing with the work with only a few children it would it make a difference to the children who missed a session when they returned. This was another decision to be made in the role of facilitator. I decided that I would continue to meet with the remaining children. This meant that at the following meetings I had to adapt and work flexibly to include the children who had missed a session yet keep the therapeutic process moving for the children who had not missed any sessions. Again a challenge for me as therapist and facilitator but one that worked out well and from my observations it was not detrimental to any of the children. The use of the feedback part at the beginning of a session allowed me to adapt my approach in response to 'between session changes' no matter what the gap between sessions had been for a child – again a 'thinking on my feet' experience for me.

5.4 Chapter summary

This chapter has charted the journey from theory to practice. It has provided an outline of what happened during each session and included my own reflections as therapist and facilitator. As stated at the beginning of this chapter the sessions

were lively and dynamic but hopefully something of this has been brought to life to do justice to the efforts of the children who took part.

Signposting to Chapter 6

The following chapter will describe the process of analysis of the data and will present the findings from this analysis. The analysis of the data was carried out using the process of Interpretative Phenomenological Analysis (IPA). The data will be discussed in relation to the analysis process.

Chapter 6 Analysis and Results

The research set out to study the experiences of a group of children during and after they participated in a group process which combined two different therapeutic processes: Eye Movement Desensitization and Reprocessing (EMDR) and Solution Focused Brief Therapy (SFBT). A further aim of the research was to explore the process from my own perspective as the therapist and facilitator of the intervention. This chapter will begin by outlining the method of analysis and describe the analytic process which was used to analyse the data gathered. In this respect, the theoretical underpinnings of Interpretative Phenomenological Analysis (IPA) will be provided. This method of analysis was chosen due to its flexibility and its ability to be carried out in real world contexts such as those of the children in this study. The audio tapes of the interviews with the children reflect emotion and animation. The words alone do not always portray the feelings behind some of the comments. In order to bring something of this expression to life I will add my comment on the results. This will include my observations and reflections on what I noticed during the process. Sometimes some of the language suggests that I know how someone is feeling. I recognise that this goes beyond just reporting but feel it is important to include.

6. 1 Method of Analysis: IPA

The aim of this method of analysis is to focus on the lived experience of the participants and to attempt to construct the symbolic worlds and social realities of participants. As a method, therefore, it fits with the aim of this research which was to examine the children's experiences of the therapeutic process carried out which combined aspects of SFBT with elements of EMDR, described more fully in chapter 3. The method is also in keeping with the second aim which was to examine my own experiences as facilitator of the therapeutic group-work process. The chapter will then go on to describe the results from the data gathered.

Theoretical underpinnings and assumptions of IPA:

IPA is a relatively new qualitative approach which was developed specifically within psychology by Jonathan Smith. IPA involves trying to understand the experiences an individual has in life, how that individual made sense of the experiences and what meanings those experiences hold (Smith, 2004). The assumption underlying IPA is that people are self-interpreting beings. Making sense of experiences is seen as central to human experience and action. The approach is in contrast with attempting to produce an objective statement about an event in terms of pre-existing conceptual or scientific criteria. IPA operates at the level of the individual and assumes agency to the individual. The method favours open-ended questions and prioritises participants' accounts in order to gain rich and detailed descriptions of the phenomenon being investigated. I

chose IPA to make sense of the findings from the data collected in this research as the approach fitted with my aim to study the experiences and perceptions of the children who took part in the group-work. The theoretical underpinnings of IPA, phenomenology, hermeneutics and symbolic-interactionism are summarised below.

Phenomenology

Phenomenology developed from the work of Husserl who, in the early twentieth century, attempted to construct a philosophical science of consciousness. Theorists such as Heidegger (1927 -1962) moved from a philosophical discipline towards existential and hermeneutic dimensions. When applied to research, phenomenology is the study of phenomena: their nature and meanings (Finlay, 2005). In IPA, the researcher attempts to understand the psychological world of the participant. IPA attempts to understand lived experience and how participants themselves make sense of their experiences. IPA is phenomenological in that it explores an individual's perception of an event. It is concerned with the meanings that individuals ascribe to events, in this case, the meanings that the children who took part in this therapeutic group-work ascribed to their situations and experiences.

Hermeneutics

Hermeneutics is concerned with interpretation. The aim of IPA is realised through the interpretive activity of the researcher. IPA focuses on an

individual's cognitive, affective and physical being (Smith and Osborn, 2003). IPA is concerned with how individuals make sense of their experiences. The researcher aims to assume an insider perspective (Conrad, 1987) and plays an active role in the dynamic process. However, IPA also takes account of the researcher's own conceptions in the process. In this sense a dual interpretation process (double hermeneutic) is taking place where 'the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world' (Smith & Osborn, 2003: 51). In this study the research aim is to explore my own experience of the process as I try to make sense of the children trying to make sense of their world. My position is that of insider. I attempted to assume this perspective and played an active role in a process that was dynamic.

Symbolic interactionism

Symbolic interactionism sees the individual's social world as enacted and hence as involving the interplay of significant gestures, symbols and systems of meanings embedded within a significant social context (Pidgeon, 1996). In the analysis the researcher engages in interpretive work. This is described, by Pidgeon as, "unravelling the multiple perspectives and common-sense realities of the research participant". In this case the participants are the 5 children who took part in the group-work. My task as researcher was to unravel what was revealed.

6.2 IPA and the current research

IPA attempts to provide a detailed analysis of elements of the reflected personal experience of the participant. The IPA method is idiographic, working at the individual level. This current research did not set out to make predictions or claims at a general level and therefore IPA provided an approach which could make specific statements about the individuals who took part in the group-work. However, the analytic process is such that it allows connections to be forged between themes and across cases. This flexibility allows for a detailed examination of the interview transcripts across individuals. The starting point for the method of analysis used rested on the practice of the *Epoche,* the on-going effort of the researcher (myself) to suspend or 'bracket' previous assumptions or understandings (Finlay, 2005). As discussed above, the aim of IPA is to provide an in-depth examination of people's lived experiences and to give a rich description of how they make sense of these experiences. The aim is to allow the phenomenon (the children's experiences of the therapy) to present itself rather than imposing my preconceived ideas on it. IPA assumes agency to the individual. The meanings that the children ascribed to their situations and experiences were reached through a process of social engagement and by a process of interpretation. IPA was chosen as the method of analysis which could provide the means of answering the questions posed in this study. These are restated below:

Main research questions

1. How do children experience a process which combines therapeutic approaches from the two distinct theoretical backgrounds of SFBT and EMDR?

Subsidiary questions

i. Are the children able to identify aspects that they found helpful from either of the therapies?

ii. Do the children use any of the skills that they have learned during the sessions outside of the therapy sessions?

iii. Do they combine any techniques from the two backgrounds?

iv. Is there any evidence that the therapy made a difference?

2. How does the therapist/facilitator experience this process?

In the previous sections the theoretical underpinnings of IPA were outlined and the method was linked to the current research. I will now outline the data collected before considering the analysis of this data and presenting the results from the analysis.

6.3 Doing the analysis

I chose to leave a gap between the end of the sessions and the interviews with the children. I wanted to see if they remembered their experiences and whether or not the therapy had any impact on them after the sessions were over. The

interviews with the children took place 2 months later. I also decided to plan for a further gap before interviewing the teachers and the parents. These took place 4 and 5 months respectively, after the last session. I wanted to check if any changes that may have occurred were still evident then, rather than merely an immediate effect from the sessions. The study did not set out to measure long-term effect but I was interested to see if the children appeared to be continuing to use any of the techniques. I was also interested to see if the teachers or parents reported any noticeable changes in the children's behaviour after this time delay. That notwithstanding, the follow-up interviews were arranged within the time constraints of the school calendar and of my study. The data collected after the group-work sessions are outlined in table 3.

Type of data	Time of collection
Comments made by the children in individual semi-structured interviews (appendix 11: child 2). Checklist of activities children liked and found helpful (appendix 12: child 2).	2 months after the group-work was completed.
Information provided by the teachers during an interview consisting of open-ended questions (appendix 13). Teachers repeated the Self-Esteem Indicator: Primary (appendix 14: child 2). Teachers repeated the Behavioural Indicators of Self-Esteem (BIOS) (appendix 15).	4 months after the group-work ended.
Information provided by the parents during an interview consisting of open-ended questions (appendix 16).	5 months after the group-work ended.

Table 3: Data collected after the group-work sessions. (The information provided from the teachers and parents was not subjected to analysis but will be considered as a means of corroboration.)

6.3.1 Process of analysis

The comments made by the children in the semi-structured interviews were subjected to a process of analysis in line with the principles of IPA (appendix 11 provides an annotated transcription of the interview with child 2). I also took into account the completed checklists depicting which activities children liked

and those they found to be helpful (appendices17 and 18, respectively, show the boxes ticked by child 2).

Finlay (2005) highlights the need to engage in reflexive analysis moving back and forth in a kind of dialectic between experience and awareness; between studying the parts and the whole. I approached the analysis of the data with this in mind. In summary this could be described as systematically reading the transcripts by first dwelling on the phenomenon and then describing constituents and recurring themes. The responses to the interview questions were subject to analysis in line with Interpretative Phenomenological Analysis (Smith, 2003). IPA is an iterative process. The stages of the analytical procedure are similar to those of thematic analysis. However, I was looking in detail at the phraseology used for the meanings that the children gave rather than trying to encapsulate words, phrases or sentences into a word. Whereas in thematic analysis the themes are attached early in the analytic process, in IPA the themes are attached later. In this way the analysis is steeped in the children's understanding. The stages involved in the process of analysis are detailed below.

Preparation stage

The audio taped semi-structured interviews with the children were transcribed verbatim for the purpose of detailed qualitative analysis. Each interview was considered individually. Key themes were elicited using the following process.

Stage 1: Open reading

The individual interviews were read and re-read to produce an open form of annotation. The notes were wide-ranging and comprised my initial thoughts and observations. These notes were recorded in the left margin of each script (see appendix 11).

Stage 2: Labelling of themes

Each interview was considered question by question and those words and phrases which appeared striking were highlighted. The interview was then re-read to identify themes. Labels were attached to these themes. These were recorded in the right margin of each script (see appendix 11). Each transcribed semi-structured interview was analysed in this way.

Stage 3: Clustering of themes

The themes identified during the first two stages were listed and considered in relation to one another to identify clusters of themes, some of which shared meaning, whilst others related in a hierarchical structure. During this procedure the original texts were checked to ensure the accuracy with which these themes were reflected in the original interview transcripts. Themes that were not well represented in the data or those which were not relevant to the questions under examination in the thesis were excluded at this stage.

Stage 4: Structuring of themes

A summary table was produced structuring the themes. This included the cluster labels with a list of subordinate themes appertaining to each cluster. (These are presented in chapter 6, section 6.4).

Stage 5: Integration of cases to form master themes

(i) Firstly, the emergent themes in each transcription were compared across cases. Comparisons of responses from each transcript were considered question by question. This resulted in a list of master themes (Clusters).

(ii) The intervention had combined aspects from two different therapeutic approaches. The transcripts were compared to examine responses which specifically related to therapeutic techniques. In this respect responses were analysed to examine any statements which highlighted aspects identified as making a difference to the children.

(iii) Finally, the process was examined child by child. This was done by examining the original data provided by the teachers, the parents and the child him/herself and comparing this with the data provided by the teachers, the parents and the chid after the group work had been completed. This resulted in the identification of what appeared to me to be a separate journey made by each child from the start of the work to a different point at the end of the process. This theme is presented as a therapeutic journey.

6.3.2 Reliability

As a means of providing some level of reliability an educational psychology colleague analysed one transcript. This colleague had some knowledge of the research that had been carried out. The data was analysed blind to identify themes. The colleague was not familiar with IPA. Instead a thematic analysis was carried out. Whilst some other form of reliability may have been better this provided a degree of concurrence (5 out of 6) in terms of themes. The theme not identified by this colleague was the theme that I labelled "therapeutic journey".

This process of analysis will be highlighted in more detail through a discussion of the results. The main features from my process of analysis are illustrated in figure 2.

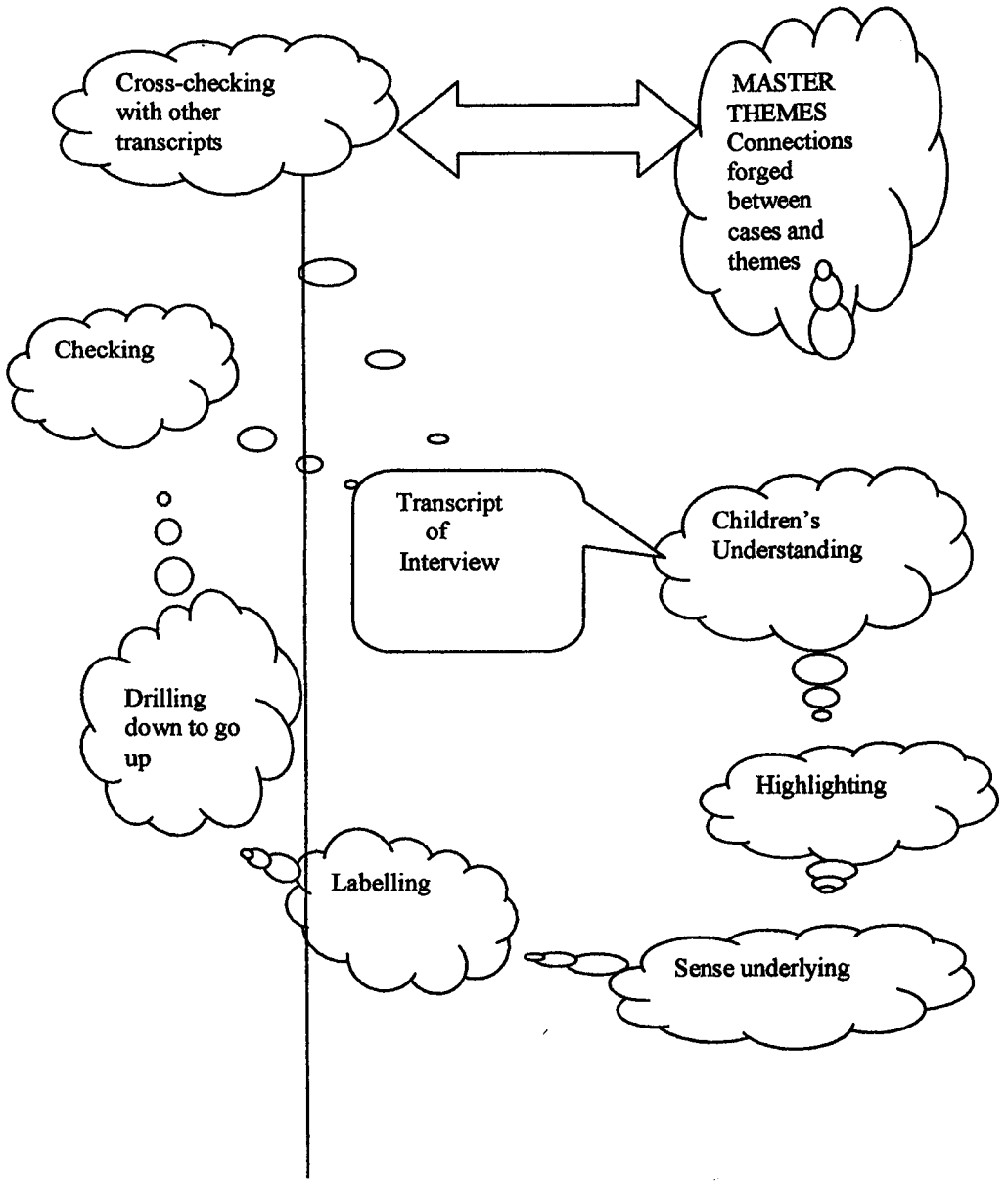


Figure 2: The process of analysis

6.4 Master themes

The particular questions used in the semi-structured interview were chosen in an attempt to tap into the areas identified in my research questions. The interview transcripts were examined in respect of the first main research question and the three subsidiary questions. In particular data provided in response to questions 3, 4, 6 and 9 of the semi-structured interview were used to consider the subsidiary questions (appendix 10). The choice of themes which I will discuss later in this chapter was based on the prevalence of the themes and on the richness of the particular passages in the transcripts that highlighted the theme. I also took account of how the themes illuminated other aspects of the children's accounts.

The analysis involved an iterative process carried out in a structured and systematic way. Firstly, I read the data to gain a sense of the meanings highlighting significant words, phrases and sections. I went back to the data checking. Labels were attached. These were then compared with the other transcripts and checks were made for new themes. Master themes were identified. 6 master themes were identified through the process of analysis. Themes 1, 2 and 3, 'The therapeutic journey, 'Therapeutic techniques' and 'Generalisation', relate to the first research question including the subsidiary questions posed at the start of this study. These will be examined in the next section in the light of the children's responses to the semi-structured interviews. This will be followed by an examination of three further master themes which emerged from the analysis, 'Locus of Control', 'Relationships' and 'Feelings'.

These surfaced in each child's interview. Themes 2 to 6 consist of a number of subordinate themes which form a cluster and contribute to the master theme. The themes illuminated by this study are presented in table 4.

	Master themes	**Subordinate themes**		
1	The therapeutic journey			
2	Therapeutic techniques: what made a difference?	EMDR techniques	SFBT techniques	Combination of techniques
3	Generalisation	Use of EMDR	Use of SFBT	Future template
4	Locus of control	Human agency/ power	Self-efficacy	Effect
5	Relationships	Family support	Group support	Friendship
6	Feelings	Happiness	Laughter	Empathy

Table 4: Themes

The identified themes will be presented in the reminder of this chapter. Master themes 1 to 6 refer to the first main research question and the related subsidiary questions. (Examples of the children's comments in respect of all themes are

provided in appendix 17). The chapter will conclude by considering the second main research question, how does the therapist/facilitator experience this process. The findings will be discussed more fully in chapter 7.

6.4.1 Master theme 1: The Therapeutic Journey

This theme relates to the first research question: How do the children experience a process which combines therapeutic approaches from two distinct theoretical backgrounds of SFBT and EMDR? and, the fourth subsidiary question: Is there any evidence that the therapy made a difference?

From my examination of the transcripts and the comments made by the children's parents and teachers it seemed to me that the children who took part in the research finished their journey at a different point from where they had been when they started the process. This section examines the separate journey of each child. On examining the data it seemed to me that each child started with a negative self belief which had altered by the end of the therapy. The end point appeared to reflect a more positive self belief. Everything that I have attributed to the children is my own feelings and views. I have presented them as if they were the children's to try to bring to life the children's voices in this study. 'The "voice of the child" includes other vocal – and indeed non-vocal – communications' (Davie, Upton and Varma, 1996, p7). In doing this I took cognisance of the non-verbal communication that I evidenced during the interview process. My interpretations are based on this. Although I recognise

that it could be argued that this is not scientifically objective, I contend that this means of presentation is in keeping with the theoretical underpinnings of IPA. The data from the semi-structured interview carried out with each child was examined and provided evidence to support this analysis. Comments made by the children during the interviews are provided to demonstrate the shift from their original position to a different end point. I will be making a judgement for each child of what I think their journey was. I make these attributions based on my analysis of the statements made by the children not just as researcher but also as a therapist.

In the EMDR protocol devised by Francine Shapiro (described in chapter 2, section 2) the therapist is required to ask the client to form an image of the target which is causing him distress. He is then asked to say what he believes about himself when holding this image. This is known as the 'Negative Cognition'. In the group work with the children I had deliberately not focused on a distressful situation. My intervention was devised to use a solution focused approach as a means of engaging the children in a process. I did not wish to focus on any distressing situations for the children. Instead I asked each child to identify something that the child would like to be better at. One child chose spelling, two children chose maths, one child chose basketball and one chose maths and spelling. I did not ask the children to identify a negative cognition. The EMDR protocol goes on to ask the person to say what he would prefer to believe about himself. This is called the 'Positive Cognition'. The theory is that

during EMDR the person processes the distressing material in a safe way and is able to make sense of what has happened (Shapiro, 2001). The successful completion is that the level of emotional distress is reduced and the client is able to function better in his current situation. In the course of EMDR therapy the person processes distressing negative material and through the processing of the distressful material the client will move from the previously held negative cognition about himself to a positive cognition. In other words his cognition about himself changes. In the standard protocol of EMDR the therapist then uses a method of bilateral stimulation (eye movements or tapping) to install the client's positive cognition with the original memory. For example, the individual may start with a negative self-belief such as "I am not safe" and by the end of the therapy this has changed to a more positive self-belief such as "I can start being in control".

As I considered the transcripts I was moved by the depth of emotions that the children shared with me. Some talked of their fears, others about loneliness and one child described how she had felt previously when she had been subjected to bullying behaviour. As the children spoke through the texts it seemed to me as if there was a new story appearing. In examining the data from each of the interview transcripts it seemed to me that each child had made a journey from a point where the child had held a negative belief about himself or herself to a position where he/she held a more positive self belief. This process occurred without these beliefs or cognitions being overtly identified by me at the start of the therapeutic process.

As I examined the data from the interview transcriptions in more detail I gained a sense that each child's narrative exposed an underlying theme. The following section outlines my interpretation of the journey made by each child. In order to illuminate these journeys I have attempted to choose labels which attempt to epitomise the start and finishing point of each journey. As I continued my analysis of the interview transcripts it emerged that the words selected by me to describe the starting point for the child's journey could be considered as a negative cognition. Similarly, the words selected to conceptualise the end point for each child could be considered as a positive cognition. The attributions that I have ascribed to each child will be presented as a journey from a negative to a positive cognition. The descriptors for these negative and positive cognitions are drawn from the analysis of the comments made by the child and my own interpretation of the sense of this from the theme that permeates the interview overall. Quotations from the interview transcripts are provided as exemplars to provide evidence for my interpretations. The comments made by the parents and teachers were used as a means of corroborating the children's perceptions of themselves.

Child 1

Negative Cognition: I am alone and different ..... Positive Cognition: I can be myself

This boy appeared to be lonely and seemed to find it difficult to make friends. He was described by his parents as a sensitive boy who worried about things.

His interests were different from the other children in the group. For example, he talked about his interest in classical music; he played the piano and was not involved in playing football in the playground, an activity that most boys engaged in at the school. His parents reported that he did not have any friends at home. As I got to know him better during the therapy sessions and from my examination of the transcript of his interview it seemed to me that relationships with other people were important to him. He had been moved to a different class a few years earlier due to the need for the school to reorganise the class groups at that time. He had not known many, if any, of the children in the new class grouping. He may not have had many friends in his previous class but the children there had at least been familiar to him. The following indicates how this boy experienced a new sense of confidence and this appeared to have had a positive effect on his life.

Interviewer (I) .. Okay. So if there was a video camera in your classroom making a film of you now what might Miss – (teacher) see in the film that was different from before you started coming to the group?

Well, em.. having a laugh with Miss - and em talking to her about ss.. things.

I: And what else might she see?

> ***That I've em... got more confident with my work and em.. that em..... and I've started to em talk to people that I wouldn't really talk to in class cos em. So like I've made friends with new people and ..... she would've saw that I've em made quite a lot of new friends.***

This boy talked a lot about other children. He seemed aware and sensitive. Being included in the group appeared to be important to him and the group-

work experience appeared to be a catalyst for him. He said that he had gained confidence and made new friends in school and at home. He also befriended another child whom he perceived to be alone in the playground.

I: ..... And what do you do now then that shows you that you've made friends with them?

> ***Well em... R** (child 5) **and.. R's just like somebody before the group I would just like say hi to when I was passing but sometimes I'll play games with R and D** (boy who was not in the group).*

> ***And em.. sometimes S** (child 3) **comes to our, our classroom for em... for drawing at golden time and then like I talk to him then too and in the playground sometimes cos I see A** (child 4) **alone I'll feel sorry for her and ask her if she wants to come and play.***

The experience of being part of the group seemed to have been very important to this boy. From his conversation it seemed as if he had learned to value himself as he was, despite having different interests from the other children. He also appeared to be accepted by the other children and he was proactive in approaching some of the other children. This was corroborated by his teacher and by some of the children during the group sessions.

Child 2

Negative Cognition: I am not safe.....Positive Cognition: I can become confident and be in control

This boy talked about a number of areas in his life where he experienced anxiety. He was fearful of new situations. He had difficulty expressing his

feelings and his teacher and his parents told me before the group started that his face twitched at times. He was a solitary boy who only had one friend. He was described by his teacher as a fairly able boy who struggled with maths.

As I examined his interview script I gained a sense that the world seemed a scary place for this boy. He reported that he hated swimming and was not confident in the water. This had also surfaced at one of the group-work sessions. When the children were giving feedback on what had happened between sessions this boy said that he had been worried about having to dive into the swimming pool and had decided to use tapping. We had practised the butterfly hug the previous week. He explained that he had improvised by tapping with his index fingers rather than with his hands so that he would not be noticed. As he was doing the tapping he visualized the pool as a large golf hole (another improvisation from an imagery exercise that I had used with the group). He played golf and without any prompting he had incorporated his hobby into a visualisation and used the tapping. He told us that this had helped and he had managed to dive safely into the pool. We had not done this in the sessions. This boy had used what he had experienced within the group and he had been able to adapt it to personalize the approach in a way that worked for him. He appeared to have a good imagination and had used this creatively to help him manage what had been a very frightening situation for him. In the interview he talked about previously hating swimming and not feeling confident in the water. The tapping and visualisation appeared to have reduced some of his anxiety in this

situation. He also described a number of situations in his life where he was anxious and did not feel safe. His vivid imagination probably increased his anxiety at times. For example, he talked about believing in ghosts and this caused him to have difficulty sleeping at times. He said that he had been frightened if he was out after dark but 'doing the tapping helps when you're scared'. Although his anxiety was not completely removed this boy's conversation suggested that he now experienced a less frightening world.

Formal EMDR treatment could have been a possible approach to use in view of the type of anxieties that this boy was experiencing. However, this research study was not designed to focus on the children's problems or negative events in their lives. Instead, the process had been designed within a solution focused context. The target for the work for the children had been something that they wanted to be better at. The choice for this particular boy had been maths. It seemed that without overtly addressing the problem, the solution focused framework combined with EMDR (tapping) while focusing on a positive resource, helped this child to deal with sóme of the problems in his daily life. The experience within the therapy sessions appeared to have provided him with the tools and confidence to feel able to apply his new knowledge in a creative way in the real world. In a sense because of his experience in the sessions he was able to take some control of the frightening situations in his life and learn from the results of this action.

Child 3

Negative Cognition: I am no good ..... Positive Cognition: I believe in myself

This child said very little within the group sessions. His responses to questions were short and he did not interact much with the other children. He took part in the activities but his verbal feedback was brief. I checked with him that he wanted to continue coming to the group and he confirmed that he did. In the final interview he said that he had found the scaling questions helpful. One of the benefits of scaling questions is that they do not require much verbal communication. In the sessions this boy did not open up and discuss how he felt about things. Had this boy been offered traditional counselling it is unlikely that he would have engaged or benefited in the same way. By being in a group he did not feel under pressure to speak about his feelings. In the group he spoke very little yet he reported that hearing the other children talk about their experiences was helpful. It is possible that listening to the other children talking about their experiences during the therapy helped him to process his own thoughts and make sense of the experiences without having to talk to others about it.

As mentioned in chapter 2 section 2, EMDR therapy is different from the more traditional talking therapies. The process does not require the individual to discuss issues or feelings in depth. The processing is largely internal with a minimum of verbal feedback. There is, however, a focus on a negative or traumatic event as part of the target for the bilateral stimulation. Some children

find this difficult to do. Others are not even aware that they have a problem or they do not relate their current difficulties to such an event. It seems possible that for a quiet or withdrawn child who avoids conversation the scaling technique from solution focused brief therapy offers a concrete tool that can help the child to make sense of his feelings without having to talk about them during the therapy.

I: Which particular parts of the work made you think about this differently do you think?

> ***Probably the bit where we were up around the room and every'hing. Like eh runnin' around the room.***

I: ... How do you think that made you feel differently? What was different there...

> ***Cos you didn't like you had each other, you're tapping each other shooders an' then you didnay like yeh, yeh didnay have to say any'hing you just had to 'hink aboot what you had done, wha, what you could do an' every'hing so.***

This approach appeared to work for this boy. He was not asked to speak about his situation. Instead, he was free to process internally and it appears from what he said that he had related what he had experienced in the sessions to possibilities for him in the future. In the group he did not interact with the other children. He often appeared tired or disengaged. This child did not seem to have a sense of any positive resources. In one of the activities another child identified him as having a good dress sense. This appeared to act as a catalyst for child 3. He had not realized previously that anyone thought positively about

him and he often 'put himself down'. In a sense it appeared that for this child the other children acted as positive resources. When asked what he had learned from the group-work he replied ***"To believe in yourself"***. He went on to explain that this meant not to doubt yourself.

> ... ***to say that you can dae some'hing an' then try.***

This boy did not discuss what was going on in his thinking but in his own quiet way it seems that he was processing information from his experience during the therapy sessions. One of the activities in particular appeared to have made an impact on this child. I had used the animal "Strengths Cards for Kids" as a resource to teach the children a concept. There were different cards each with a particular concept depicted metaphorically. I had chosen the cards to explain in a narrative form some aspect that I believed was relevant to the children in the group. I had chosen to use these cards in an attempt to incorporate an element from EMDR. In EMDR treatment there is often a psycho-educational phase of the treatment. In this phase an individual is provided with information about his situation to help him to make sense of what has happened to him. This boy had learned a lesson from the card that pertained to his own situation without being directed specifically to that card. He had said at the beginning that he wanted to be better at maths. Within the group-work we did not do any maths work. Yet he felt that his maths had improved.

I: ...How did that help then?

> ***It's*** (the animal cards) ***just sayin' that eh some animals are good at other things but some arnay so good so. So I just says thought I was***

like I was good at like my spellin' and every'hing but I'm not that good at maths. When I first came I wasnay that good at Maths even if my ma maths... and then when I started goin' I can do my maths in like at least about twenty minutes now...

The message on one of the animal cards had resonated with this boy's particular situation. He had related it to his negative belief about himself and his cognition had changed to a positive one where he believed that he could achieve. In EMDR terms he had processed the stuck material from the past and he was now able to function better in his current situation. The therapeutic approach using SFBT and elements of EMDR seemed to have made a difference to his self-efficacy. This could be evidenced in his behaviour in the classroom and was confirmed by his teacher.

Child 4

Negative Cognition: I'm stupid .....Positive Cognition: I can achieve

Before the therapy this girl rarely spoke in class even when she was asked a direct question. Her teacher said that at times she refused to do her maths or written work and would not say why this was the case. She was described by school staff as having learning difficulties. After the group work her attitude to school work changed. The impact of the therapy also appeared to have generalised to other parts of her life. In the group she chose to focus on improving maths and spelling. After the therapeutic work she engaged with school work in a way that she had not done before. When interviewed she

reported that she did not give up now and even though she might get things wrong she would try again. She also told me that she used to daydream and that she often refused to write or speak. Her teacher confirmed this change in her engagement in the classroom. Her behaviour at home also changed, as evidenced by her parent. This girl was very aware of the changes in her behaviour. Her responses demonstrated how pleased she was with these changes.

> ***I never done my homework but now I'm catching up. And I'm really, really confident.***

I: ... What else was helpful? You've told me a bit about that already..... (At this point she was so keen to tell me of her successes that she didn't wait for me to finish).

> ***That, that, that I'm catching up with my times table.***

I: .... Uh huh. So after you've, you've been through all the groups and it's all finished now you're back in your classroom and you're doing all your work everyday ... If there was a film made of that what would be different on that film with that was different from a film before you met me and came along here?... What.. what might you be doing differently?

I might [I: Now] be doing.. other things that people wi..would be doing. Like..... Like probably.. being... Like probably learning new things.

> .. *(sighs)* ***If she***(my teacher), ***if she ..probably realise that I'm learning more than I used to like day dreaming .. and, and now I'm not day dreaming I'm just concentratin'.***

Although still behind her peers in attainments, this girl appeared motivated to learn. She was working at her own level to reach her potential. She seemed aware of the changes in her life since the therapy and was able to articulate

those changes. It seemed to me that she was beginning to take control of her learning.

When asked what she would like to improve the target areas chosen by this girl had been spelling and maths. The group-work had not involved any direct work or practice in these subject areas. Instead the focus of the therapy had been on increasing inner strengths and resources in an attempt to help the children to develop a positive self belief, in other words, a sense of self-efficacy. Despite not working on the academic subjects in the sessions this girl is making progress in both of these areas, as reported by her teacher. A clear relationship has been found between self-efficacy beliefs and academic productivity (Tuckman & Sexton, 1990). This child now seemed motivated in the classroom. Belief in yourself appears to influence goals for which you strive (Dweck, 1992). It seems as if the therapeutic group-work made a difference to how this child responded in class. Seligman *et al.* (1995) makes the point that developing a competency of any kind strengthens the sense of self-efficacy making a person more willing to take risks and to seek out challenges. This girl seemed to be more willing to try things in class. Previously she would often refuse to write and at times would not answer her teacher.

I was also interested that the effects of the group-work seemed to have permeated not only spelling and maths but other aspects of this girl's life too. Just having high efficacy, however, is not enough to ensure true self-eseem and

intrinsic motivation; these efficacy beliefs must be accompanied by a sense of autonomy (Deci and Ryan, 1995). This child talked about changes in her life at home such as keeping her room tidy and doing her homework before watching television. She also spoke of taking care of her health (asthma) by not running in the playground. It seemed from the responses this child made during the sessions and from her responses to the semi-structured interview that this girl now had a sense of autonomy.

Child 5

Negative Cognition: I am not likeable..... Positive Cognition: I belong

This girl told me that she had been bullied at school. Her attendance had been poor and she said that she often lay awake at night worrying about going to school the following day. She also reported that she had a poor memory as she had dyslexia. She seemed to view herself through a 'disability' lens. Her perception was that she could not do academic work and was different to the other children. She was embarrassed that she had to attend learning support in school and felt that her peers would know where she was going when she went out of the classroom. At home she spent a considerable amount of time in her bedroom and rarely went out of the house. After the therapeutic intervention this child described a life where she had positive social relationships both in school and in her local community.

.. an' sometimes at night ah have lack eh sleep wonderin' what's gonna happen to me .. tomorrow .. em.. on... like a year ago ah was gettin'

bullied so much ah... ah was ill then ah couldn't.. Ah didn't go back to school.. just in case.

Now I've got tons of.. got lo.. tons of friends.

This girl was animated as she spoke about the changes in her life. She described in detail how she was part of a group of children in school and at home. She was now fully engaged in their games and mentioned many children by name. It could be argued that just by being in the group increased her friendships but she also talked about initiating a relationship with a new girl who joined her class. She also told me that she now had a number of new friendships both at home and in school. The new relationships outside of school were also remarked upon by her mother during the follow-up interview 5 months after the group-work had finished.

New friendships had also developed outside of school. Her mother confirmed that she no longer stayed in her bedroom and that girls came to the house to ask her to go out with them. Being accepted and belonging seemed very important to this girl. Previously she had been isolated and worried about going to school in case she was bullied. Now she was popular and had lots of friends at school and at home. It seemed that being included by her peers and a sense of belonging had given this girl confidence in a number of areas in her life. She explained that her attainment levels had increased from level B to level C on the 5 to 14 national attainment tests and that she no longer went to learning support. The following quotation exemplifies the changes that had occurred for this girl.

Before we were goin' a'd be quiet an' get on with my work and .. sometimes ah, ah wouldn't even speak at all ... noo a'd be talking to ma friends. She'll see higher standards .. of my work .. and my maths cos I'm really good at ma maths. And.. am gettin' everything right on ma spellin' test .. And.... the, the smile on ma face at points.

Section summary

The above theme charted the journey each child appeared to have made. This has been presented as a journey from a negative cognition about themselves to a point where they appeared to hold a more positive belief about themselves. There was a sense of changes such as feeing less anxious and more confident in tasks, some talked about coping better with their academic work and some spoke animatedly of new friendships. It was humbling to appreciate the emotions that the children experienced. As I considered the data I realized how difficult it must have been for these children to function well in a classroom situation. In the circumstances it is not surprising that they appeared anxious, quiet or withdrawn.

6.4.2 Master theme 2: Therapeutic Techniques

The following section examines the first subsidiary question: Are the children able to identify aspects tat they found helpful from either of the therapies? This master theme includes techniques that the children found helpful. These will be considered under the headings of EMDR, SFBT and techniques which the children combined. Examples of statements made by the children will be

provided for each section. In addition, I will provide a commentary based on my analysis.

Subordinate theme: EMDR techniques

In EMDR psychotherapy bilateral stimulation is used to facilitate the processing of negative material from an earlier traumatic event that is causing distress for the individual. This method of bilateral stimulation is also used in what is referred to as the installation into the system of a positive cognition or positive resource. The bilateral stimulation can be using eye movements or tapping (see chapter 2, section 2). Eye movements were not appropriate in a group situation. The method of bilateral stimulation that I chose to use instead was with tapping.

Examination of the data from the semi-structured interviews indicated that all of the children in this study had found tapping helpful. Some of them told me that they used this method to help them outside of the therapy sessions. For example, one child explained how he experienced a mental and physical change following the tapping.

Child 1

> ... ***and em also tapping is.. on sh..shoulders can like em make me feel more relaxed and like sometimes when I can't go to sleep I use the tapping too.***

All of the children mentioned the positive effect after tapping. One child explained that he had also found an activity involving marching in a circle

helpful. This activity involved each child tapping the shoulders of the child in front as they recited a positive self–statement. This child found these tapping activities useful and related them to helping him to feel more confident. The activity where tapping was used to tap the shoulders of the child in front was also mentioned by another child.

The marching activity is not an element used in the standard EMDR protocol. However I decided to incorporate this for a number of reasons. Firstly, I posited that the alternate use of the legs and arms in a rhythmic fashion which is required in marching mirrors bilateral stimulation. Secondly, in my view, there is a need to work creatively when working with children. The marching activity could be seen as a fun element, as evidenced by child 4.

Child 4

> ***I liked it when we, when we went around in a circle tapping each others' shoulder...because it made me laugh a lot.***

All of the children mentioned that they found the positive self-statements helpful. The children did not distinguish between the marching activity and the activity which included both marching and tapping. Therefore, it is not possible to say if repeating a positive statement while marching is sufficient on its own to make a difference or whether tapping is also required.

Some of the children were creative in the way they used the techniques that they had learned. For example, one child used tapping when he went swimming. He was very anxious about diving into the water and explained that he had not wanted to use across body shoulder taps as we had practiced in one of the sessions as this would be noticed by his peers and the teacher of whom he was fearful. Instead he creatively used finger taps in a more subtle approach that was less noticeable. He told the group during a feedback session about this and said that it had helped his self-confidence at the swimming lessons. During the semi-structured interview another child said that he had used a similar method in school. He appeared to have listened child 2 and tried this adaptation out at a later stage in another context. It would seem that there was a learning element within the group feedback sessions which added to the repertoire of other children. A third child spoke about her creative use of tapping in the classroom.

Child 5

> ***The pattin' on the shoulder was definitely .. helpful. Because ah had a test coming up .. and ah passed it.... Instead of pattin' on the shoulder ah just pat around my waist just in*** *[I: Ah right]* ***because the t..table's below the below ma waist so*** *[I: Uh huh]* ***nobody can see what ah was doin'.***

Section summary

The above section outlined the techniques from EMDR that the children reported as being helpful to them. All of the children mentioned some form of bilateral stimulation. They all found tapping helpful. The butterfly hug,

marching and affirmations (positive cognition statements) such as 'I can do it' were also found to be helpful. The next section will consider what the children had to say in respect of the techniques from SFBT.

Subordinate theme: SFBT techniques

Scaling questions were used in different ways during the therapy sessions and to elicit information during the interviews with the children. For example, they were used in the first session to establish each child's subjective view of themselves in relation to their chosen topic that they wished to improve. They operated as a tool to support the children in the process without them having to find language to communicate their feelings. This can often be a difficult thing for children to do especially when they have not conceptualized their underlying problem. SFBT looks for solutions rather than problems. The children responded well to this technique during the therapy and in the interviews. However, only 2 children mentioned these specifically during the interviews. Only one child appeared to use scaling questions outside of the sessions. She reported that she still used this technique several months after the final therapy session. As I examined the transcript of this girl's interview I was reminded of her excitement when she described how she used the scaling technique. She spoke quickly and was clearly animated.

Child 5

> ***..... and ev.. the wee purple, the pink book you gave us av, I write some down and.. put a scale eh one to ten .. sometimes have five, sometimes have nine, sometimes have one.***

I: ... And you use scaling in it. Mmm mmm [R: Yeah]. How does that work then? How do you do that...?

> ***Well, um... Instead of puttin' a big long line of one to ten, .. I put different stuff like hearts, stars ..***

I: Right. Okay. And what kind of things might you'd scale what might you do it on?

> ***Em.. Ah.. Sometimes ma like ma nerves .. ma happ.. When am happy, sad .. excited. ...So ah can, ah can record what I've been doin' since.. an' remember what ah did before an' ah can do it again .. to make me more happy....Or if it was sad a'd try, I'd try an' do the opposite of it.***

This girl obviously found scaling helpful, so much so that she used it regularly. She was able to tune into her emotions and she used her own personally adapted version of scaling as a tool to monitor her emotions. She was then able to self-regulate.

Child 3 said that he had found the scaling questions useful during the group-work. He said that he liked this as didn't have to talk about how he was feeling. This child had often appeared quiet during the group-work. In fact, I had checked with him that he wanted to remain in the group. It appears that, for this boy, a technique which did not require him to speak about his personal situation and feelings had been enough for him to restructure his thinking. In other words, a solution orientated structure had helped him to process his own thinking in a positive way.

It seems that SFBT was used less often by the children than EMDR. However, the child who continued to use it on a regular basis found it very helpful. As I read and re-read her transcript I was struck by the energy expressed in her words. Her experience had changed her dramatically from that of a quiet shy girl who had stayed in her room at home to a girl who was now living life to the full. It seemed to me that by using this technique she had found a way of gaining some control over her life.

Subordinate theme: Combination of techniques

This section examines the third subsidiary question: Do they combine any techniques from the two backgrounds? The therapy had used techniques from two different therapeutic approaches. The following section draws on reports from the children to examine this question.

I: ... Are there any things that we did that you think worked together? You know,
they worked well together?

Child 1

> ***Well em.. you asked us to em imagine.. your name and em make it more bold, make it more brighter, add colour to it and like if you want add music and add some movement.***

This child had remembered this in detail. This suggests that he had been motivated by this activity. It is possible that the laughter and shared amusement within the group in response to one child's amusing visualisation may have

been a motivator. If this is the case, then working therapeutically with a group of children rather than on an individual basis, could have added potential.

Child 2

Em... Well, em... Like you mean sort of like um tapping your should... em sorry se em soldiers (shoulders) em and em sort of going around the room and things.

Child 3.

Tapping and closing your eyes and sayin' 'I could do it'.

Child 4

The butterfly hug and the... drawing.

All of the children were able to identify elements that they felt worked in combination. There was a variety of combinations mentioned. A number of children mentioned positive strength statements in combination with tapping. One child talked about drawing helping her to focus and the butterfly hug helping her to concentrate more. Another child spoke of talking and then scaling. It would appear that different techniques worked for different children. However, positive self statements featured throughout the transcripts from all of the children. They were either used on their own or in combination with another technique.

6.4.3 Master theme 3: Generalisation

I noticed as I read and re-read the transcripts that some of the children were talking about their lives outside of school. I examined each transcript to see if the children mentioned EMDR or SFBT in relation to any activities at school or at home. Examples found were tidying the bedroom, practising lines for a play, at the swimming baths and in bed at night to help get to sleep.

This theme relates to the second subsidiary question: Do the children use any of the skills that they have learned during the sessions outside of the therapy sessions? Firstly, I will consider this in respect of EMDR. Secondly, I will look at what the children had to say in respect of SFBT.

Subordinate theme: Use of EMDR

This theme examined the use of techniques from EMDR. All of the children reported that they had found tapping helpful. They used it to help with various activities in and out of school. Some children adapted the tapping to use it in a less obvious way. One girl taught the butterfly hug to her parent. She said that her mother had been nervous before attending a job interview. This would seem to demonstrate this child's belief in the efficacy of the approach. She proudly shared that her mother was successful and got the job. Two other children mentioned using the butterfly hug to help prepare for school tests. I was also impressed that some children went on to use the butterfly hug creatively in a way that was meaningful to their own situations.

Subordinate theme: Use of SFBT

A number of children said that they had found techniques from SFBT helpful within the sessions but only one child mentioned using the techniques from SFBT outside of the sessions. Child 5 said she had found the scaling technique from SFBT useful and she had incorporated it into her daily life. She was using it creatively to help to improve her life.

Section summary

The children seemed to have found techniques from SFBT helpful during the sessions, for example to help them talk about themselves. However, only one child mentioned using SFBT techniques outside of the sessions. It may be that SFBT helps some children to engage with a therapeutic process. The tools from EMDR seemed to have been seen by these children as having more impact in their lives once the process was over. All of the children used some of the techniques that they had experienced during the sessions outside the therapy sessions. The children used what they had experienced in the sessions to help them at home, in school and in community activities such as swimming. They used them for various reasons. The therapy was delivered in a group setting. Yet, as I examined the various transcripts and compared and contrasted the responses made by the individual children it seemed that they had used the techniques in a way that was personal to them. They had adapted the techniques from the group-work to suit their own particular circumstance often doing this in a

creative way. I was reminded of my approach when planning the design. I had chosen to use a flexible and creative design to meet the individual needs of the children in the study. It occurred to me as I examined the scripts that, not only had the children experienced the activities and techniques in the group sessions, but they had also experienced my personal style of delivery. I wondered if perhaps they had learned something from that too.

It is clear from feedback that the children shared their experiences during the sessions and their use of what they had learned with their parents. This demonstrates how committed the children were to the work and their belief in the efficacy of the techniques for them. When I spoke to the parents after the group-work was finished they confirmed that their children had spoken about it to them during the process. They told me that usually the children did not volunteer information about what happened at school. This indicates that the work seemed to have been important and they chose to share some of their experiences with their parents. It also appeared to have had an impact on the children's lives during and after the therapy sessions in a number of situations. The children related their feelings of confidence and success to their use of these strategies. It is possible that this belief will provide them with a feeling of being in control.

Subordinate theme: Future Template

How might their experience help them in the future?

I examined the transcripts to see if the children made any comments which indicated that they related anything that they had learned in the sessions to their future. In order to cross check between scripts I compared the responses to question 9 on the semi-structured interview (appendix 10). All of the children were able to link their current experiences to possible future events. They were able to envisage how this new learning might impact on them in the future. For example, one boy linked the therapy to a new sense of self-confidence and a belief in his own abilities. He related this to being able to do his work. He experienced success in maths and this in turn appeared to have a positive effect on his motivation. He reported that his behaviour had changed and he went on to explain how he would try at maths even when the task seemed difficult. This was in contrast to previously believing that he was not able to succeed in maths and consequently giving up. The following comments illustrate how the children viewed their future.

I: ...So my next question is what have you learned from the group work that will help you in the future?

Child 1
The tapping.... in university and in high school when I'm doing my exams cos I want to be teacher.

Child 2
..... like I can be confident at things... in the future.

Child 3
To believe in yourself. Not to get down on yourself an' just to try what yeh want to dae.

Section summary

As described earlier in this chapter, all of the children made direct connections between what they had learned in the sessions and how they thought this experience had impacted on their current situations. In addition, they were all able to link their experiences from the therapy sessions to possible future events. The children were all able to describe how, in their view, what they had learned in the group-work would make a positive difference to their lives.

6.5 Emerging themes from the data provided by the children.

The previous section examined the first research question and the related subsidiary questions posed at the start of this study. These were examined in the light of the children's responses to the semi-structured interviews. As I examined the data three further master themes emerged from the analysis. These surfaced in each child's interview. I ascribed the following labels to these master themes:

- **Locus of Control**
- **Relationships**
- **Feelings**

Each theme consists of a number of subordinate themes which form a cluster and contribute to the master theme. These three master themes and the

subordinate themes within each of these will be illuminated in the next part of this chapter.

6.5.1 Master theme 4: Locus of Control

As I examined this data I noticed that confidence and self-belief were mentioned by 4 of the 5 children. This resulted in the identification of the master theme 'locus of control'. By this theme I mean words and phrases that indicate the child's perceived control over his or her behaviour. This relates to attribution theory and is classified as 'internal' if the child felt in control of events and 'external' if others are perceived to have control over events.

Within this theme were:

i. ***'human agency/power'*** encompassing intentionality, forethought, self-confidence/relying on one's own power, self-reactiveness and self reflectiveness.
ii. ***'self-efficacy'***, the belief that one can perform a behaviour including competence, ability and skill.
iii. ***'effect'*** which included choice, intention and persistence.

Subordinate theme: Human Agency/Power

Throughout my reading of the scripts I was struck by the number of times that the children mentioned tapping as being helpful. This led me to examine the texts more closely to see what it was that appeared to be helping them and their perception of the effect. In a sense it seemed to me as if the tapping gave the

children some control and helped to reduce feelings of anxiety. This is illustrated below.

Child1

The past couple of times when I've not really been confident about something... I was a wee bit scared today because I was the first narrator to stand up and introduce the play and em at home when I learning my lines I was tapping my shoulders and t..today I didn't get a line wrong.

Child 2

...it also helps when you're scared as well. The tapping sort of.. it like acts.. like sort of.. em.. sort of someone like with me, beside me and things.

Subordinate theme: Self-efficacy

From the analysis of the data there seemed to be a theme appearing in all of the transcripts which related to self-efficacy. For example, one of the boys talked about how he believed that he was no good at written work and maths. His perception of himself appeared to have changed after the group-work as evidenced by some of his comments during the interview.

I: Tell me something that you learned from the group work?

Child 3

To believe in yourself. When I first came I wasnay that good at Maths even if my ma maths... and then when I started goin' I can do my maths in like at least about twenty minutes now...

One of the girls described herself as dyslexic and related her poor attainments to this. Before the therapeutic work this girl did not believe in herself. Afterwards

this seemed to have changed. She talked of being more confident and appeared to believe in herself.

Child 5

> ***She'll*** (my teacher) ***see higher standards .. of my work and my maths cos I'm really good at ma maths. .. and .. ma spellin' is comin' on. Am gettin' everything right .. on ma spellin' test...***

Subordinate theme: Effect

This subordinate theme related to the effect that the experience of the group-work appeared to have on the children. As I examined the data I noticed that each transcript included comments from the children which indicated what I chose to label the 'effect' of the group-work. One child described how she could learn new things now in the classroom whilst another said she did not go to learning support any longer (the underlying message being that her work had improved so she no longer required this additional support). In particular tapping was mentioned by all of the children as being effective. They mentioned this in a number of different situations both in school and at home. Some of the children said that tapping helped them to relax. Some also reported that tapping helped them to concentrate better.

6.5.2 Master theme 5: Relationships

By this I mean interaction between the child and another person; a feeling of security from another person or setting; support from another person and providing support to another person.

Subordinate theme: Family support

Some of the children reported that they talked to their parents about the group-work. One said he told his parents what he had learned each time he attended the sessions. Another said that she had taught her mother to do the butterfly hug as she was feeling anxious about having to attend an interview the next day. One boy said that he gave his brother praise and related this to having been in the group. Two children said that their parents would notice a change in their behaviour at home. It would appear that the children valued the sessions and wanted to share what they had learned with their family.

Subordinate theme: Group support

The children all said that being in a group was preferable to being on their own to do this therapy. They gave different reasons for this. Examination of the interview transcripts highlighted a number of reasons given by the children for preferring to be in a group rather than individual therapy. For example, it seemed that prior to the group-work some of the children thought they were the only ones with a particular problem. These children said that by being in the group they became aware that others children have similar problems. Other comments included feeling included rather than isolated.

Child 2

...you like em realise that you're not the only one who's not confident.

Child 3

Well you dunnay feel on your ain.

Child 5

.. you feel, you feel like you're blending in with the other people.. and havin' conversations with them.

The above examples provide a flavour of how the children described their feelings. All of the children expressed a change from having felt alone, isolated or different from their peers. They often used different words and yet the underlying theme was the same. As I examined the various scripts I became aware that each child appeared to have a more positive perception at the end of the group-work. Their worlds were described as happier places to inhabit.

The children all said that they would recommend a group like this one to another child. They offered different reasons for this. It is possible that the effect of being in a group had a positive bearing on the results. Certainly from the children's reports the delivery of this therapy within a group-setting was viewed by them as positive. This was particularly true of one boy as can be seen from his response to my scaling question.

I: So on a scale of one to ten now that you've finished the group - remember you said at the beginning, before you came to the group, "I was kind of a bit of a five - where would you put yourself now about how much you liked being in the groups eh if one is not very much and ten is I really loved being in the groups?

Child 1

Ten.

Subordinate theme: Friendship

Four of the five children had made new friends during and after the group-work. One of the boys had been to a residential camp. This was a joint camp with children from other local primary schools who were all due to transfer to the same High School after the summer holidays. His teacher reported that she was surprised at his popularity with a number of girls.

One boy continued to have only one friend. He did not make any new friends either in the group or elsewhere. One girl did not mention friends. This did not seem to be a priority for her. However, one boy in the group went out of his way to speak to her when he saw her standing alone in the playground.

6.5.3 Master theme 6: Feelings

By this I mean emotions felt by the children or emotions that they perceived other people to have. This theme includes empathy – the ability to imagine someone else's experiences and enter into them. Conversely, this theme includes lack of empathy or being absorbed with self. The subordinate themes contributing to this theme are:

i. Happiness

ii. Laughter

iii. Empathy

Subordinate theme: Happiness

The children seemed to be able to identify a feeling of happiness and talked about this in the structured interviews. Some spoke directly of feeling happy after the intervention. A number of children talked about increased friendships and related this to their feeling of happiness. For one girl this was in direct contrast to how she had felt previously when she described not wanting to go to school due to concerns that she would be bullied. This girl had talked of only playing with her cousin or younger children in school and staying her room at home. After the intervention she spoke animatedly of many new friendships both at school and at home. Some children talked of moments within the sessions that made them feel happy. For example, one girl mentioned that the visualisation activity had made her feel happy during the group-work. Another child related his new sense of happiness to having received a compliment about his clothes during a group session. From my observation of his behaviour and reports from his teacher this seemed to be a turning point for this boy leading to an increased sense of self confidence.

As I read the transcripts and checked across cases there was evidence that all of the children experienced a feeling of well-being during the sessions. It also seemed from the statements of the children during the interviews and the stories that they told that they all experienced a greater feeling of well-being afterwards.

Subordinate theme: Laughter

This was primarily a therapeutic intervention. However, as the participants were children I had created some of the activities in a way that I felt would be enjoyable and motivating for them. The following quotations serve to illustrate that fun and laughter were important aspects for the children.

Child 4

> ***I liked it when we, when we went around in a circle tapping each others' shoulderb...because it made me laugh a lot.***

Child 1

> ***Well em.. you asked us to em imagine.. your name and em make it more bold, make it more brighter, add colour to it and like if you want add music and add some movement and then em... after that yeh asked us what we all em saw [I: Uh huh] and then I all I remember after that is just (child 5) telling us what she saw and us all bursting out laughing.***

During the group-work I had observed the children laughing and generally appearing to enjoy the activities. They had engaged in the activities and had appeared motivated. This was corroborated by what the children said in the interviews.

Subordinate theme: Empathy

The children varied in the degree of awareness and empathy expressed. I noticed during the sessions that two of the children appeared to be self-absorbed whilst the others appeared to be more perceptive and aware of others.

As I examined the transcripts I noticed that one boy was highly aware of others and sensitive to their feelings. He looked out for another child from the group who was alone in the playground and he befriended her.

Child 1

> ***Well, em..... Just like.. just for you em.. em I'm not sure if this is the vocabulary to use it but em .. you're considerate about other people.***
>
> ***...and em I can be a friend.***
> ***..... and in the playground sometimes cos I see(child 4) alone I'll feel sorry for her and ask her if she wants to come and play.***

However, not all of the children were so aware and considerate of others. I noticed that two children appeared to be at the other end of the spectrum, being almost unaware of the feelings of others. From some of their comments they seemed self absorbed and egocentric. I was struck as I was analyzing this data at the wide diversity there was even in this small group. For example, even though I attempted to explain to child 2 how child 3 might have felt when he received the compliment about him having style in his clothes, child 2 was unable to put himself into the shoes of his peer. This boy also did not even remember the other child's name. In contrast was child 1 who was extremely insightful and sensitive to the isolation of one of the girls from the group when they were in the playground. Another child spoke of taking more care of herself after the intervention. This girl did not mention others but at the same time she did not appear to be self-absorbed. Instead the sense I got was that she had come to

value herself and she was now aware of the need to take care of her health. Despite the differences in degrees of sensitivity to others, all children said being in a group was helpful.

Section summary

The previous section reported on some additional themes which emerged from my examination and analysis of the data from the interviews with the children. These themes were not directly related to the research questions but they appeared significant and were evident in each child's transcript. I therefore chose to include them in the results section.

6.6 Congruence

In this section I will compare the comments made by the teachers and the parents. I will also attempt to relate the children's reports to what was said by their teachers and parents.

There was some congruence between how the children were explaining themselves and how that was being transmitted, through my analysis with the reports from the teachers and the parents. Comparisons of comments made by the teachers and the parents appear to support the view that the changes were observable.

The experiences of the teachers and the parents were not subjected to a process of IPA. This research set out to examine the experiences of the children. However, on reflection IPA could have been applied to the data collected from the teachers and the parents. The results of this further analysis could have offered further insights. As a practitioner I was interested in considering how the teachers and parents experienced the children after the group process. Whilst I am aware that there is no methodological certainty I examined the statements to see what is added to the picture. A comparison of the statements made by teachers and parents before the intervention is provided (appendix 18). Similarly, a comparison between the statements made by teachers and parents after the intervention is provided (appendix 19). I also compared comments made by the teachers before and after the group-work for any evidence of change, to corroborate the children's perceptions of themselves (appendix 20 teachers). A similar comparison was made in respect of the parents' comments (appendix 21). Results from a comparison of statements of teachers and parents provide some evidence of agreement. There was some congruence between how the children were explaining themselves and how that was being transmitted, through my analysis with the reports from the teachers and the parents. Comparisons of comments made by the teachers and the parents appear to support the view that the changes were observable.

As mentioned previously, I was also interested in whether or not any changes appeared to be lasting. The interviews with the children provided some

indication that changes were sustained after the completion of the intervention. This was not designed to be a long-term follow-up, although I acknowledge that it would be interesting to carry out longer-term evaluation. However, in the months that followed the intervention teachers, parents and children reported continuation of this change. My final meeting with the children took place 4 months after the last session. The purpose of this meeting was to bring closure to the group. At this meeting I asked the children to draw a picture to illustrate how they felt now (The drawing made by child 2 is provided in appendix 22). The children were also asked to share what was better and what they were doing that helped (appendix 23).

6.7 My Experience of the Process

In the previous section I presented the results of the analysis of the data from the semi-structured interviews with the children in relation to the first research question and the subsidiary questions as outlined at the beginning of this chapter. I also presented 3 additional themes which emerged during the analysis. In the following section I will consider the second main research question posed at the start of this research: How does the therapist/facilitator experience this process?

6.7.1 What was my role?

The purpose of the enquiry was to illuminate the experiences of the children and my own experiences. The method of analysis as outlined earlier in this chapter was IPA. The perspective taken of social constructionism sees interaction and

interpretation as part of the process of making sense of the world. During the sessions I certainly interacted with the children and took an active role both as therapist and facilitator. The approach that I took was not a static set of activities with a prescribed formula. It was not a 'take off the shelf' set of tasks to present within a group. Instead, the therapeutic nature of the group-work meant that it needed to be a dynamic process based on the responses of the children. As therapist I therefore, interpreted these responses and adopted a flexible approach to the sessions based on my interpretation of these responses.

The following provides my attempt to illuminate my experience as therapist and facilitator of the process. Experience is of itself subjective. This could be seen as a criticism of this approach. However, I would argue that the research was intended to seek my own experiences of this novel process. It was not my intention in this research to measure and record objective categories. IPA was chosen as the method to suit the subjective experiential nature of the research questions. My own experience is described within the parameters of the IPA method. I bring to this analysis my training as a teacher, an educational psychologist and as a psychotherapist. I also bring my experiences over many years working with children.

Perhaps the first point to consider when addressing this question is 'what was my role within the process: was I a facilitator or was I a therapist?' Certainly I planned the therapeutic process combining aspects from EMDR and SFBT. I

used these creatively within the sessions and I applied many of the skills of a therapist and counsellor such as active listening, summarising, reframing and building positive relationships. I was present in the moment with the children as the therapist. I was attentive to their behavioural responses such as facial expressions and gestures. I listened to the feedback from the individual children during the sessions and at the start of each new session in a way which could be described in therapeutic and counselling terms as 'active or deep' listening. I responded to relevant feedback therapeutically during the sessions. I used an integrative approach to therapy drawing on appropriate techniques. In this sense then I was the therapist within this process.

However, due to the context within which I had chosen to do this research I also played another role in the process. It was a group setting with 5 individual children of different ages and from different classes in the school. Many of them did not know each other or had only passed each other in the corridors of the school. Each child brought his or her own individual issue together with a different experience and view of the world. In other words, each child had his or her own story. It was necessary, therefore, for me to adopt the position of facilitator in order to manage the complex nature of the undertaking. I needed to be able to provide therapy to meet the needs and circumstances of each individual child within the context of a group of children.

My role then, as I saw it, was both that of therapist and facilitator. The balance of this role depended on which part of the process was taking place and what was happening in the sessions at any one time. As therapist it seemed to me as if I was operating at a different level from the 'pragmatic me' who was in the role of facilitator. In the role of therapist I used counselling skills to listen actively and to respond therapeutically. For example, I was aware that in my therapist role I needed to keep each child engaged in the therapy and use the writing and drawing as a stimulus for this process. At other times I found myself switching backwards and forwards between roles. For instance as facilitator, I was aware of the discrepancy between one child and her peers in terms of writing and drawing. My skills as facilitator came into play as I managed this complex process. I needed to judge how long to allow for the slowest child to work on her writing or drawing so that she was not disappointed to be stopped before she had finished. Yet at the same time, I had to ensure that the other children did not lose interest. The therapeutic element needed all children to remain engaged in the process rather than becoming too absorbed in the stimulus or switching off due to boredom. On another occasion, I noticed that I was joining in an activity, the butterfly hug. I was aware that I found this activity calming and it seemed to help me to concentrate better on the next steps with the children. In this sense I was also a participant in the group. This juxtaposition between the role as facilitator and that of therapist was in itself complex and sometimes it was happening at an unconscious level.

Section summary

The above section has described my experience both as facilitator and as therapist. Due to the complex nature of this study and the context for this research it was necessary for me to adopt the position of facilitator in order to manage the process. However, this study was designed to be a therapeutic piece of work. Therefore, I have also examined my experience in a therapeutic role. My experiences varied at different points of the process depending on the particular demands of the situation. My experience could be described as varied and complex. However, my overall experience of this process was an enjoyable and positive one. The role of facilitator and therapist will be discussed more fully in chapter 7.

6.8 Chapter summary

This chapter has examined the results from the data gathered. The two main research questions and the four subsidiary questions were addressed. 6 master themes were identified through the process of analysis. The first of these was presented as a journey for each child. Themes 2 and 3, 'Therapeutic techniques' and 'Generalisation', related to the first research question and the four subsidiary questions posed at the start of this study. In addition 3 further themes which emerged during the process of analysis were presented. These were 'Locus of Control', 'Relationships' and 'Feelings'. The chapter concluded by considering the second main research question in relation to my own experience of the process.

Signposting to Chapter 7

The following chapter will discuss issues emerging from this research study. I will also highlight some of the implications, with particular reference to educational psychologists.

Chapter 7 Discussion and Conclusion

The aim of this chapter is to relate the findings of the study to the main research questions posed at the beginning of this research in order to consider the implications. The chapter will start by revisiting the questions posed. This will be followed by a summary of the findings. In chapter 1 I began by providing the background to my study. In this final chapter I will explore where I am now on my own journey. I will attempt to make theoretical sense of the process in relation to the literature and discuss my own reflections on the process. The chapter will then suggest possible implications for practice and end by drawing some final conclusions.

7.1 What did the research aim to do?

The general aim of this research was to study the experiences of a group of children during and after they participated in an innovative therapeutic process which combined two different therapeutic processes: Eye Movement Desensitization and Reprocessing (EMDR) and Solution Focused Brief Therapy (SFBT). A further aim of the research was to explore the process from my own perspective as the therapist and also the facilitator of the intervention. The main research questions were:

1. How do children experience a process which combines therapeutic approaches from the two distinct theoretical backgrounds of SFBT and EMDR?

Subsidiary questions

i. Are the children able to identify aspects that they found helpful from either of the therapies?

ii. Do the children use any of the skills that they have learned during the sessions outside of the therapy sessions?

iii. Do they combine any techniques from the two backgrounds?

iv. Is there any evidence that the therapy made a difference?

2. How does the therapist/facilitator experience this process?

The research was undertaken within an applied psychology perspective. The therapy was delivered in a group setting in the context of the Scottish Education System. The aims of the research, as stated above, were realised. These are summarised below.

7.2 Summary of findings: first research question and subsidiary questions

The research did not set out to measure whether or not the therapy made a difference to the children. Instead I chose to use a qualitative approach to explore the children's experiences. However, from the analysis of the data collected a picture emerged which indicated that the children in the study had made a shift in the way they felt and how they viewed themselves. This

appeared to have led to a change in the manner in which they functioned in their daily life. The findings indicate that the experience of taking part in this group-work which combined the two therapies of SFBT and EMDR appeared to have made a difference to the children in a number of ways. They were able to transfer learning from the therapy setting to their everyday lives; they described a change in how they felt about themselves; their schoolwork improved and they had better relationships with peers. The children were able to identify aspects of the therapy that they had found helpful and they were able to generalise this learning to aspects of their lives outside of the therapy room. They sometimes adapted techniques and used them creatively. In addition, they described how their new learning might impact on their future lives in some way.

The children's reports were corroborated by their teachers who reported evidence of improvements in the classroom. In addition, parents reported improvements at home. It appears then, that despite not setting out to directly measure behavioural change there were indications that changes had occurred. My previous experiences working with individual children had shown me that some children find it difficult to discuss or even acknowledge a negative issue in their lives. I did not want to focus on a negative event in the group-work. This meant that I had to devise a method that would somehow target a pertinent issue for the children without explicitly asking them what was worrying them or affecting their lives. By asking the children to focus on something that was a

personal goal for them the therapy appeared to have addressed a deeper underlying issue for each child. The children reported positive changes in their everyday lives.

7.3 Making theoretical sense of the children's experiences: solution without a problem

The following section attempts to make sense of the above in the context of EMDR and SFBT theory.

Despite not overtly focusing on a negative or problem situation for the children they were able to describe their own individual journeys from negative self-image to a positive view of self. Morris (2002) identified three components of self-esteem: sense of self; sense of belonging; sense of personal power (see chapter 5). It would seem from the children's reports that after the group-work they each had a more positive sense of self. They also spoke about new friendships and about experiencing a sense of being included. In other words, there appeared to be a sense of 'belonging' rather than feeling isolated or different from their peers. The children talked about using the techniques that they had learned from the sessions in situations in school, at home and in the community. These techniques and their experiences of success in the classroom and outside of school could be said to give them a sense of personal power. In a way then, the effect of the therapy could be said to meet the three components of self-esteem highlighted by Morris. The children achieved in tasks in a way

that they had not managed before. Their perception of their own competency appeared to have had changed.

Kernis (1995) makes the point that trying to raise self-esteem directly may have limited success as this ignores the fact that many of our feelings about our selves come from what we do rather than cause us to do it. Self-esteem can only arise from competencies in real-life situations (Seligman, 1998). My method had been devised to allow each child to work with a competency that was meaningful to the child. The children had chosen to work on competencies from their own lives, areas where they wanted to improve. The children reported improvements in the chosen areas and these improvements were confirmed by the teachers and the parents. Dewck (1992) concludes that belief in yourself tends to influence goals for which you strive. McLean (2004) talks of the dynamic interplay between self-efficacy (judgements about our abilities in certain areas) and self-esteem: self-efficacy contributes to and is enhanced by positive self-esteem. What implications then can be drawn from the above for the children in this study? If indeed the children's self-efficacy beliefs have become stronger this could contribute to their feelings of positive self-esteem and the dynamic interplay between the two would contribute to their increased self-efficacy. Bandura (1997) makes the point that people make causal contributions to their own psychosocial functioning through mechanisms of agency. He goes on to cite beliefs of personal efficacy as being central and pervasive among the mechanisms of agency: efficacy beliefs influence how

people think, feel, motivate themselves and act. However, according to Deci and Ryan (1995) just having high efficacy is not enough to ensure true self-esteem and intrinsic motivation; these efficacy beliefs must be accompanied by a sense of autonomy. Seligman *et al.* (1995) asserts that developing a competency of any kind strengthens the sense of self-efficacy making a person more willing to take risks and to seek out challenges. It seemed from the responses that the children made during the sessions and during the semi-structured interview that they appeared to have developed a greater sense of autonomy, a sense of personal agency and a greater sense of self-efficacy. The experience within the therapy sessions appeared to have provided them with the tools and confidence to feel able to apply their new knowledge in a creative way in the real world. They were at least beginning to believe in their own capabilities. In a sense because of this experience in the sessions they were able to take some control over their situations and learn from the results of this action.

Tuckman and Sexton (1990) report that a clear relationship has been found between self-efficacy beliefs and academic productivity. My study did not set out to measure academic achievements. However, the reports from the teachers support the children's perceptions that they have made progress in academic subjects. The children talked about feeling more confident and related this to their achievements in the classroom and to their relationships with other children. It is not possible to say that these were a direct result of the therapy –

and I reiterate that this was not the intention of the study - however, it appears that something has changed in the lives of the children.

7.3.1 How does this relate to EMDR?

In the standard EMDR protocol devised by Francine Shapiro (described in chapter 2, section 2) the therapist is required to ask the client to form an image of the target which is causing him distress. He is then asked to say what he believes about himself when holding this image. This is known as the 'Negative Cognition'. In the group-work I did not ask the children to identify a negative cognition. My intervention was devised to use a solution focused approach as a means of engaging the children in a process. I did not wish to focus on any distressing situations for the children. Instead, I asked each child to identify something that he or she would like to be better at. The children identified maths, spelling and basket-ball. The EMDR protocol goes on to ask the person to say what he would prefer to believe about himself. This is called the 'Positive Cognition'. The theory is that during EMDR the person processes the distressing material in a safe way and is able to make sense of what has happened. The successful completion is that the level of emotional distress is reduced and the client is able to function better in his current situation. In the course of EMDR therapy the person processes distressing negative material and through the processing of the distressful material the client will move from the previously held negative cognition about himself to a positive cognition. For example, the individual may start with a Negative self-belief such as "I am not

safe" and by the end of the therapy this has changed to a more positive self-belief such as "I can start being in control". In other words his cognition about himself changes.

In examining the data from each of the interview transcripts it seemed to me that each child had made a journey from a negative belief to a position where he or she held a more positive self belief. This process occurred without these beliefs or cognitions being overtly identified by me at the start of the process. In effect, by using EMDR within a solution focused framework to target the work, it appeared that each child had made a journey from a negative self belief to a more positive self belief. In a sense each child described what seemed to me like a journey which started from a fear or anxiety that had been affecting the child's life even though I had not talked about that fear or anxiety during the therapy. The journey ended at a different and more positive place for the child.

In the standard protocol of EMDR the therapist then uses a method of bilateral stimulation (eye movements or tapping) to install the client's positive cognition with the original memory. Instead, my method drew upon Resource Development and Installation, developed by Andrew Leeds (1998) (see chapter 2). This basic EMDR Resource Installation Protocol was devised to increase an individual's capacities to access adaptive resources outside of the therapy setting and to prepare vulnerable clients for trauma work. I adapted this flexible procedure to the needs of the children and delivered it within a solution focused framework. In this way, EMDR contributed to the outcome. The use of the

'butterfly hug' technique as devised by Lucinda Artigas (see chapter 2) also appeared to be particularly helpful to the children. They reported using this between sessions and this continued to be used after the therapy was over. One child even taught her mother this technique. This technique, which uses bilateral stimulation, appeared to strengthen the children's internal resources and helped them to deal better with situations that they had previously found frightening or difficult. The children certainly believed in the efficacy of the butterfly hug and used it in real-life situations to support them.

The children in my study reported that they had found tapping (EMDR) helpful. They said that it helped them to feel relaxed. They also said that it helped them to concentrate better and they reported feeling more confident. This agrees with findings from Armstrong's (2007) study which explored the experiences of children who had undertaken and completed an episode of EMDR therapy for the resolution of PTSD after a single trauma. Armstrong suggests that the dual focus of attention in EMDR helped the children in her study to concentrate better and thus talk easily about traumatic memories. She also suggests that the eye movements helped them to relax and make memories fade. My study did not focus on trauma. However, the children reported similar effects. They appeared to cope better with tasks that they had previously found difficult. It is possible that something similar was happening. It may be that the dual focus of attention helped them to concentrate on the positive statements about themselves, for example, the words 'I can do it'. Similarly, being relaxed may

have helped the negative beliefs fade and allow them to attempt the task without the negative thoughts getting in the way.

7.3.2 How does this relate to SFBT?

When working therapeutically with adults the problem is usually described to the therapist by the client. Children often find it more difficult to articulate what is causing them a problem in their life. The children in this study did not present themselves to me for help. Instead they were identified by their teachers as having a presenting concern. I had not wanted to focus on what was wrong in the children's lives. I was not even aware if they saw themselves as having a problem before the study. I did not wish to use a deficit model or label them in any way. In some ways this presented me with a problem. I was concerned that if I talked about their difficulties as perceived by their teachers and parents I may be raising concerns to a level that may not have been apparent to the children previously. In effect, I could have made them more anxious. The dilemma for me as therapist was how to attempt to reduce or resolve a problem that was not articulated. In SFBT as used traditionally the therapist does not ask the client about the 'problem'. Instead the therapist uses language, particularly solution focused questions, to ask about times when the problem is not there or when the situation is a little better. Although not necessarily stated, the underlying assumption is that there is a problem for the client. Indeed, early process research examining SFBT (chapter 2, section 1) indicated that clients often felt 'unheard' if the therapist did not allow them to talk about the problem

situation and later versions of the approach accommodated this by allowing some 'problem talk' at the beginning of a session. In my group-work, as mentioned above, I did not focus on problem talk. In fact, the children were told that we were going to work to help them with something that they wanted to be better at. It is possible that by asking the children to choose something that they wanted to be better at I may have covertly highlighted to them that they had a problem. However, I would argue that any such assumption on the part of the children was likely to have been around a problem achieving in their chosen topics rather than an issue with anxiety or confidence.

7.3.3 What might be happening?

Within SFBT the imbalance of power of the traditional psychotherapies is relocated within a social constructionist perspective. The role of the therapist is to take part in conversations and to facilitate the telling of stories. The therapist and the client co-construct a new reality together (Chapter 2, section 1). It is my view that within the current study my role had been to work with the children to co-construct a new reality with them. In keeping with the underpinnings of SFBT I did not need to know their underlying concern in order to do this. SFBT holds that individuals have the resources within them to resolve their difficulties. De Shazer draws on the work of Erickson who advocated using a client's own resources, strengths, beliefs and behaviour in the direction of change. De Shazer saw the key to brief therapy as utilising what the client brings with him to meet

his needs in such a way that the client can make a satisfactory life for himself (de Shazer, 1985).

The integrative process in my study seemed to facilitate a move towards a positive outcome for each child in terms of his or her chosen goal. There also appeared to be a positive effect on underlying issues which were not overtly targeted. As well as reporting improvements in their chosen skill area the children also reported perceived changes in relation to confidence in other areas of their lives such as improved relationships with other children and in tackling what were previously viewed as frightening situations.

7.4 Summary of findings: second research question

This section examines the second research question: How does the therapist/facilitator experience this process? The discussion that follows considers some of the issues that emerged for me as the therapist and facilitator of this integrated therapeutic approach.

7.4.1 What did I find helpful?

One of the challenges of this work for me was how to individualise therapy to meet the needs of a disparate group of children. The target for much of the group-work that takes place in schools is often based around social skills. For example, to help the participants develop strategies to manage their behaviour. Other group-work aims at developing skills, such as, communication skills.

Some groups have a therapeutic focus. Therapeutic groups usually consist of individuals who share a common issue such as bereavement or addiction. In my study the children had some commonality in that they presented as quiet, shy, withdrawn and/or anxious. The reasons for these behavioural presentations were not identified at the beginning of the therapy. I was not focusing on the children's problems. Instead, I chose to use a solution-focused approach targeting something they wanted to be better at in their lives. The choice was open-ended for each child and I did not know at the start what each of the children would choose to work on in the group. The therapy had to be presented in a way that the instructions were specific enough to be clear to each child. At the same time the instructions that I gave had to be general enough to allow each child to apply these to his or her own individual situation.

7.4.2 Researcher as participant and facilitator

The design of the study placed me inside the research context. I was a researcher participant. This experience offered me the opportunity to be fully involved in the process and to develop a therapeutic relationship with the children. My experience of this was positive. I was a facilitator and participant. At times I had to reflect and respond quite quickly. As the children did their butterfly hug tapping I joined in. This bilateral stimulation acts as a self-soothing technique. This seemed to help me to deal calmly and professionally with the complex nature of the demands. It also allowed me the opportunity to reflect on the situation before moving on.

Facilitating the group-work was an enjoyable and challenging experience. Being a participant researcher added another dimension to be considered when reflecting on my experience. I made very brief notes during the sessions as I did not want to jeopardise the therapeutic relationship with the children. If I had focused on my notes then the interaction and dynamic nature of this process would have been compromised. However, for me it was essential that I found a way of capturing some of the experiences before they were lost to me. I therefore stayed behind after each group session to write some notes of key events. The discipline of making field-notes immediately after each session was extremely useful when writing about my experiences. With so much going on in the sessions it was essential for me to have some record of the events to support my subjective views. I also recorded some of the sessions as an additional aide-memoir. The position of researcher as active participant requires a method of recording information to support and validate the experiential findings. My experience of the process was that the techniques that I drew on from SFBT and from EMDR worked well together in this study. I found SFBT techniques helpful in facilitating the process so that I could then use EMDR to deepen strengths and resources. Despite some of the complexities of the situation my experience of this process was positive and stimulating. I thank the children involved for an extremely enjoyable and illuminating experience in my roles as therapist, facilitator and participant in this study.

7.4.3 The contribution of SFBT

The complex nature of this approach meant that the procedure had to be flexible. In SFBT the emphasis is more on processes than on structures. In particular, the element of co-construction in SFBT provided the flexibility and creativity to be able to execute this complex process. In my role as facilitator I had to be alert at all times to the subtle responses of the children and respond appropriately to these as well as to their more visible responses. In some respects it would have been simpler to choose a particular issue that was common to all of the children in the group and target that issue. However, from both an ethical and a motivational perspective, I wanted to allow each child within the group to address his or her own individual issue rather than choosing a common difficulty that all of the children could work on at the same time. I had to find a method that would allow each child to work on his or her own chosen topic. Yet, as therapist, it was necessary for me to be able to check from time to time where a child was within this process. I needed this feedback to check that all was well for each child and in order to decide how to proceed with the next stage of the therapy. Children can lose interest easily. The need to be creative and flexible within the parameters of a therapeutic approach can make a difference between engagement and switching off. Techniques from SFBT assisted the facilitation of this process in a number of ways as described below.

Scaling questions

In SFBT one of the techniques is the use of scaling questions. Without the use of scaling questions from SFBT I am of the opinion that I would have found it very difficult, if not impossible, to keep each individual child engaged in his or her own process when giving a directive to the group as a whole. The open nature of this approach allowed me to gauge where each child perceived himself or herself to be in relation to the question that I was asking. For example,

On a scale where 1 is the worst it could be for you and 10 is the best it could be where are you now?

The open nature of SFBT means that it is not necessary to know about 'the problem'. SFBT techniques are about allowing an individual the freedom to do 'the therapy 'in his own head. The open nature of scaling allowed me to gauge where the individual child perceived him or herself to be on the scale. The number assigned to a certain question is immaterial in the quantitative sense. It is how the therapist and the individual involved use this information that is important. They are co-creators in the therapeutic process. The use of scaling questions from SFBT enabled me to move the process on in a safe way for each child within the setting of a group. I was then able to ask my next question to the whole group in a way that it was personalised for each child. For example,

"What is it you are doing that has made you reach your number?"

"What needs to happen to move one point up your scale?"

In this way I did not need to refer individually to the number that each child had plotted on a scale. The responses that the children made to questions such as these were subjective. This could be considered a criticism by some. However, I would argue that the subjective nature of the approach was part of the success of this work. As the scaling for an individual is a subjective measure it did not matter where they had decided was right for them. The essence of therapy is about change. My aim was to help the children see things in a different light. The change that I was interested in for these children was related to their perceptions of themselves rather than measuring observable behaviours.

Miracle question

I found the miracle question from SFBT a useful tool to enable me to personalise the therapy within the group. For example, I asked the children to visualise what their life would be like when they were better in their chosen areas.

If a miracle were to happen tonight when you are asleep and when you waken up tomorrow things are better for you what would you notice that is different?

In SFBT the miracle can be extended by asking further questions to create a more detailed and concrete picture for the client. I did not want to ask each child

separately to do this as I was concerned that hearing the detail of another child's 'miracle' might confuse the children and possibly contaminate their own imagined scenario. Instead, I asked each child to draw their image and then used a technique from Neuro-Linguistic Programming (NLP) (Bandler and Grinder, 1975) to make their image bigger and brighter. By doing this I was able to guide the children so that they were able to continue to construct their own pictures.

Feedback questions

Questions designed to elicit feedback from the children were used for a number of purposes. I had chosen to work with a group of children rather than on an individual basis. One of the difficulties when doing therapeutic work in a group is to keep a check on individual responses and progress. The feedback questions drawn from SFBT were helpful to check on this within the process. I was also able to be responsive to the feedback by adjusting my pre-planned framework in a way that was appropriate to the particular situation. In other words, SFBT provided the tools for a flexible design within the sessions. For example, *What's been different since we last met? What's been better since our last group meeting?*

These questions were helpful at the start of a new session to check anything that the children had noticed that had changed or improved. During the therapy the children listened to feedback from their peers. In this sense they were able to gain some appreciation of others' constructions. This is in line with Kelly's

constructivist 'sociality' position (chapter 4). The context of the group allowed new possibilities to emerge and shape new meanings for the individual children. The boy who had adapted the butterfly hug technique to use in the context of the swimming pool to avoid others noticing him using it was able to share this experience in the group. The other children listened to this. Later one of the other children used this adapted technique in the context of his classroom. The incidental learning which was going on during the process added to the direct impact of the therapeutic interventions. The effect of being in a group, rather than in a one-to-one situation with a therapist, added another dimension to this work.

7.4.4 The contribution of EMDR

EMDR is a therapeutic approach which has been developed to be used with individuals. The current study was developed to be used with a group of children rather than on a case by case basis. (See chapter 1 for an explanation of the rationale for this). To do this I needed to consider the practicalities of how I might use an approach which was for use with an individual in a way that it would address the needs of a group of children. One of the crucial concerns for me in carrying out this therapy was the safety and well-being of the children. This is especially crucial when working with 5 individual children within a group situation. As with any therapy the safety of the client is paramount. When working with a group of children I needed to ensure that each child was safe and supported within the therapeutic process. This was an issue that I kept

firmly in mind throughout the process. Throughout these activities my underlying concern was always to check that any visualisation or imagery was appropriate and safe before strengthening the positive future image using bilateral stimulation with EMDR. This entailed ascertaining feedback at an individual level within these group activities before moving on using EMDR.

As I was not explicitly working with an underlying concern for a child I was particularly on the lookout for any evidence of touching an emotional 'nerve' so to speak. When working therapeutically with an individual this is a necessary skill for a therapist. When working with a group of potentially vulnerable children caution and sensitivity on the part of the therapist is particularly required. All of this contributed to the complexity of being therapist and facilitator of a group process such as this and at times these roles seemed to merge. I take comfort in the words 'all healing is really nothing other than self-healing. The therapeutic task is to facilitate this process' (Zabukovec, Lazrove & Shapiro 2000, p.193). I certainly worked hard at the therapeutic task of facilitating this process.

7.4.5 My personal contribution

Two discrete psychotherapeutic orientations, SFBT and EMDR, were used to design the intervention that I used in this study. However, at times I also drew from my therapeutic 'tool bag' using aspects of other therapies such as visualisation techniques and Neurolinguistic Processing to facilitate the process,

as the situation required. As described in chapter 1 my use of these supplementary activities were in line with theoretical integration (Norcross and Newman, 1992). In a sense I see this as an aspect of what I would describe as the 'me-ness' of my therapy. This is not to say that others cannot use this therapeutic group-work intervention. Rather, I point to the creative opportunities afforded to a professional who is mindful, skilled and experienced in therapeutic work. This intervention was not designed to be a 'take off the shelf' approach. Certainly I designed the intervention with a clear structure and this will provide a framework for anyone to use. However, it was designed primarily as a therapeutic intervention, and as such, the detail should be adapted and personalised for any children who may be involved in the future.

7. 5 Making theoretical sense of the therapy

In chapter 1 I began by providing the background to my study. In this section I will explore where I am now on my own journey.

7.5.1 My Journey

As stated in chapter 1 the Standards in Scotland's School etc. Act 2000 (s2, 1) places a duty on an education authority

to secure the education is directed to the development of the personality, talents and mental and physical abilities of the child or young person to their fullest potential.

In my day to day work as a practising educational psychologist it appeared to me that some children were not realising their fullest potential despite the efforts of their teachers. As I reflect now on my thesis I take myself back to the start of my journey. My thesis was an attempt to explore a means of helping to address this issue. I set out to explore a way to remove or reduce some of the barriers to learning for the group of children who were described by their teachers as quiet, shy, withdrawn and/or anxious. My interest in therapy and my experience working therapeutically with individuals led me in the direction of a therapeutic approach. I had used both SFBT and EMDR separately in my work with individuals and I had attempted to incorporate some aspects of SFBT into my work using EMDR with children and young people. It seemed to me at the start of my journey that there may be a way of devising a therapeutic approach based on both of these therapeutic approaches to support the group of children whose progress appeared to be blocked in some way. At the start of my journey my hypothesis had been that SFBT would help the children to engage more easily in a therapeutic process. I felt that this was an important factor given that the children were described by their teachers as quiet, shy, withdrawn and/or anxious. Children with such a presentation were, in my view, likely to be reticent with a stranger and probably not keen to talk about their issues. SFBT does not require that a problem is discussed and instead focuses on solutions or times when the problem is not present. This seemed an ideal framework for my work with this group of children. I could have devised an

intervention based solely on SFBT. However, I hypothesised that if these children were presenting as quiet, shy, withdrawn and/or anxious there could well be an underlying reason for this. Some event/s or circumstances could have led to this and may have resulted in them holding a negative belief about themselves and their capabilities. The intensity of the traumatic event or events can result in a person being stuck in relation to emotional, behavioural or cognitive material that as not been processed in an adaptive way (Tinker and Wilson, 1999). My training and experience in the use of EMDR led to my plan to use this therapeutic approach as a possible means of reaching any deeper emotional aspects which may have been underlying the children's behavioural presentation.

7.5.2 What might have been happening?

In the following section I will attempt to make theoretical sense of the process in relation to the literature and discuss my own reflections on the process.

As described earlier, traditionally SFBT and EMDR are used as single therapeutic approaches. In my research I decided to integrate these two approaches in a new and innovative way. In other words, I saw both therapies offering something that could help the situation. Yet each developed from a different theoretical premise. As I reflect on my journey the link between SFBT and EMDR becomes clearer in my own understanding of the processes that were operating within my study. As described in chapter 2, EMDR originates

from a medical model which aims at targeting problems. SFBT, on the other hand, ignores problems and works with exceptions to the problem situation. How did these seemingly contradicting epistemologies work together? The key for me is Erickson's concept of 'utilisation', the use of the individual's own resources and strengths to effect change (Haley, 1993). An underlying strand from EMDR and the work of Shapiro is the central belief that individuals have the resources within them to draw upon. The use of positive resources in EMDR therapy and the supporting of the client's inner strengths parallels the underlying concept on which SFBT is based, namely, that individuals have the resources and strengths within them to effect change. The two methodologies may come from 'different stables', so to speak, but it seems to me as I reach the end of my thesis, that they both hold in high regard the power of the individual. Both EMDR and SFBT work towards the same aim: to empower the individual to draw on these inner resources and strengths and to use them in their lives.

As I consider and reflect upon the process involved in this study and the voices of the children I am reminded of narrative theory. At this point in my journey I suggest this now as a theory for what might have been happening for the children. To explain what I mean by this I will summarise some of the underpinnings of narrative.

White and Epston (1990) draw attention to how social scientists refer to the interpretive method when they are studying the processes by which we make

sense of the world. Bateson (1972, 1979) stated that since we cannot know objective reality, all knowing requires an act of interpretation. We are all interpreting beings and as such seek to make sense of events in the context of previous experience. White and Epston (1992) suggest that over time individuals develop 'stories' about who and what they are. In other words, in order to make sense of these events they are 'storied'. To make sense of life and the world we organise our experiences of events in sequences across time. The stories reflect not only past and current events but can also influence how we experience the future. Specific experiences of events in the past and present that are predicted to occur in the future must be connected to a linear sequence to develop what is referred to as a story or self-narrative (Gergen and Gergen, 1984). According to supporters of the text analogy experience must be 'storied' and it is this storying that determines the meaning ascribed to experience.

How then does this narrative theory relate to the children in my study? Each child seemed to me to have an unsurfaced story about himself or herself. For example, the story for one child seemed to be, I have dyslexia and this means that I am not clever. There were other events and experiences in this child's life but for her this was the 'dominant story'. This story was given meaning by having to go to see the learning support teacher. According to narrative theory the story could influence future experience for this girl.

White proposed a form of therapy which he called narrative therapy. Key principles from this model may shed some light on what was happening for the children. White suggests that by inviting the individual to view a problem situation as external rather than internal there is a separation between person and problem. He asserts that as the person becomes separated from her story she is able to experience a sense of personal agency. She is then able to intervene and 're-author' the story. The child in my study appeared to do this. Her new story was about being popular and about being able to do maths. This was given further meaning by a boy asking for her help with his maths work. She went on to predict her future at High School based on this re-storying. The teachers and parents of the children also appeared to re-author their stories in the light of new events and experiences with the children. In a sense the teachers and parents 're-storied' in response to the children's re-storying.

7.5.3 A proposed model

Having considered narrative theory as a means of making sense of what seemed to be happening for the children led me to go on to reflect further on this theoretical model. I wondered how my integrated design using SFBT and EMDR might relate to this model. In other words, how do SFBT and EMDR help the children to re-story?

How then did SFBT help the children to re-story? SFBT and narrative theory are underpinned by social constructionism. Within the constructionist position it

is the way people make sense of their experiences which are important for therapy.

SFBT and narrative approaches are both collaborative. They are respectful, non-blaming approaches which centre on individuals as the experts in their own lives. The elements from SFBT in my integrated therapy included questions that offered the opportunity to explore alternatives and other possibilities. The miracle question offered the children the opportunity to experience a preferred experience. This was explored in detail in vitro making a rich experience for the child. This exploring in detail of an alternative could also have helped the children to interpret events differently and so lead to re-storying their self narrative (White & Epston, 1990).

How did EMDR help the children to re-story? EMDR traditionally is based on an analogy from a clinical model. As such, on the surface the two would not seem to be compatible. And yet, as I considered this further, I began to see similarities in the approach that I had used. I had not started with a target problem. Instead, I had used some of the components of EMDR to enhance and strengthen resources. The children reported that they had found the techniques from EMDR, for instance, tapping and the butterfly hug, helpful to them. They talked about using these in their daily lives and related them to their successes, for example, in school and at the swimming pool. In this sense, some of the elements from EMDR helped the children to re-story. In EMDR there is a

psycho-educational phase where new information is offered relating to a situation. I used the Strength cards as a stimulus for this phase. I chose cards with statements pertaining to individual children (for example, 'I am good at doing some things' and 'I can change'). I would argue that the use of these cards which had statements ascribed to different animals externalised possible problems for the children. In narrative therapy terms, the children were able to separate and go on to re-story.

7.5.4 The therapeutic relationship

At this point as I reflect on my journey and the work with the children in this study it seems to me that in addition to the various techniques and protocols involved in the process there was something else happening. I will refer to this as my personal contribution. I have acknowledged earlier that I came to the research with my background training and experiences as a teacher, an educational psychologist and as a practising psychotherapist. I also brought to the study my own personal experiences, values and beliefs. This personal contribution sits comfortably within the phenomenological stance which underpins this study. However, I raise it at this point as it seems to me as I reflect again upon my role of therapist and facilitator of this process that some of the particular features that I brought may well have contributed to the outcomes for the children. In this respect I will discuss my thoughts here within the concept of the 'therapeutic relationship'.

I will provide the reader with a brief summary of what I mean by this and then locate my personal contribution within this concept. The power of the therapeutic relationship has been noted by various researchers. Many studies have investigated the facilitative conditions examining the various elements in different psychotherapy treatments. Lambert concluded that the power of the therapeutic relationship is vital in contributing to client progress (Lambert and Simon, 2008). In 1957 Rogers identified the importance of certain conditions within the therapeutic relationship, such as warmth, positive regard, respect and congruence with the client as being crucial. I was consciously, and possibly unconsciously, endeavouring to promote conditions that demonstrated to the children my respect for them and how I valued their views and their individuality within the group.

7.5.5 Mindfulness

My reflections on my personal contribution led me to consider how the therapeutic relationship might be enhanced and in so doing I was drawn to the literature on 'mindfulness'. I raise the concept of mindfulness at this stage to explain to the reader my thoughts at this point in my own journey. Mindfulness fits with a phenomenological perspective. It is a lived experience and as such is in keeping with my own philosophy and the methodology used in this research study.

Mindfulness can be viewed as a kind of shift from a 'doing-mode' to a 'being-mode' (Hick, 2008). This author views mindfulness as guiding us in how to be deeply present with ourselves and others. Hick sees mindfulness as being about cultivating, sustaining, and integrating a way of paying attention to the ebb and flow of emotions, thoughts and perceptions within all human beings. Hick goes on to assert that this kind of awareness can enable therapists and counsellors to be present in a therapeutic relationship in a way that is more about being with a client than about being a detached expert. This fits with the approach that I took in the group-work. A unifying theme in the literature on mindfulness and the therapeutic relationship is that a successful therapist is understanding, accepting, empathetic, warm and supportive. I certainly tried to be like this and I hope that I achieved this in my work. My therapeutic intervention was constructed to receive and accept the individual contributions from the children and I then adapted my approach in response to the feedback from the children during the sessions and throughout the process. The intervention was delivered in a group setting but I strived at all times to personalise the work to each individual child within the group, both in terms of goals and also in my approach. I engaged with the children, not only using the therapeutic skills of deep listening, reflecting and so on, but I would contend that my attitudes and beliefs in the importance of being there in the moment for each child and demonstrating empathy and positive regard for each child were factors which contributed to the positive outcomes in this study. This fits with Bien's (2006) view that because we are listening deeply, in touch with the patient and the moment, we

more clearly know what is needed and what is not needed. Bien makes the point that when we are in the flow of psychotherapy, just relaxed and paying attention, often wonderful things unfold, seemingly without effort. This certainly accords with my experience during the group-work sessions.

7.5.6 Mindfulness and EMDR

Shapiro (2001) refers to mindfulness when she considers some of the ways that EMDR may be impacting on a client. Shapiro points to Teasdale (1999) who identified different states of mind that may facilitate or hinder the processing of emotional material to a successful resolution. Teasdale identifies what he calls the mindful experiencing/being mode. Shapiro considers this may be what is happening during EMDR. She considers the possibility that the effectiveness of EMDR may arise from its ability to evoke exactly the right balance between re-experiencing emotional disturbances and attaining a non-evaluative "observer" stance with respect to the emotion and to the flow of somatic, affective, cognitive, and sensory associations. Shapiro posits that the client may be in an experiencing/being mode during bilateral stimulation in EMDR. Kabat-Zinn (1990) also referred to the stabilized observer stance in EMDR and compared this to meditative practices. It seems to me at this point in my journey that mindfulness may have been impacting on the children through the process of EMDR and also due to my mindful state as the therapist.

7.6 Future Implications

This research was situated in the professional practice of educational psychology. This final section offers some thoughts for the future in this respect. I also suggest some implications for research on psychotherapy based on my discussion in the previous section.

7.6.1 Educational psychology

There is often a tension between direct individual work with a child and systemic work with schools or other organizations. Systemic work has the advantage of embedding skills in the organisation in the hope that teachers will use the new knowledge and skills to meet the needs of more children. However, there still remains a demand for individual work for the children who do not manage the challenges of school despite educational psychologists providing training to teachers. Today's financial climate with limited resources means that managers of specialist services have to make hard decisions about how to target these limited resources. For some children a specialist approach will always be necessary. Intervention is one of the core functions of a psychological service in Scotland. Although it could be said that this was quite an intrusive intervention, I would argue that it addresses issues at an early stage and in this sense could be a cost effective way of making a difference to a number of children rather than perhaps needing a more intensive individual approach at a later stage. At practitioner level, the value lies in the experience of engaging with therapy in the real world, and in the opportunity to compare, contrast and

uniquely combine therapies in a helpful way for the children. For practitioners it points to the utility of employing available evidence-based therapies creatively (Grandison, 2007).

7.6.2 Psychotherapy

Research into the effect of the component parts that contribute to EMDR psychotherapy continues in the field. As this research develops there is scope to consider further the possible implications of mindfulness in the context of EMDR therapy.

There appears to be the potential of mindfulness in fostering an effective therapeutic relationship. Research to establish that the use of mindfulness by therapists cultivates the qualities necessary for effective therapeutic relationship is in its early stages. It would seem that there is scope for further research to explore any possible connections between mindfulness and the therapeutic relationship. I agree with Hick and Bien (2008) that there is a need for further research into the possible value of mindfulness practice to explore the impacts and effects of mindfulness on therapists and the therapeutic relationship, and then ultimately on client outcome. Should this prove to be the case then there would be value in mindfulness training being included in the training courses for practitioners in all fields of therapy including the training of educational psychologists.

Once more I reiterate that I did not intend to measure the individual variables in this study. However, if the facilitative conditions in my work were a factor in the positive outcomes for the children then the power of the therapeutic relationship needs to be considered in the future by anyone wishing to replicate my work.

7.7 Conclusion

My experience as facilitator and therapist supports the utility of techniques from SFBT. However, SFBT is much more than a set of tools or techniques and I wish to acknowledge the principles and values that this therapy is based on. The guiding principles for practice are based on social constructionism. The influence of constructionist thinking allowed me to construct meanings and understandings together with the children in this study. The use of language, in particular in the questions, was central to the construction of concepts and knowledge. The power of SFBT within this therapeutic process supported the process for the children and for me as the facilitator. Would SFBT on its own have been enough? Did I need EMDR? I would argue that SFBT would have taken the children some of the way. It could well have helped them in their chosen target areas of maths, spelling and basket-ball. But I am not convinced that there would have been the emotional change that appeared to have occurred, as reported by the children. What is my evidence for this statement? As stated earlier, it was not the intention of this thesis to identify the component parts of the therapy. But I do find myself speculating at this point in my journey. The

purpose of including EMDR into this combined approach was to deepen some of the positive cognitions and resources that the children had. In other words, to increase the strengths that may act as buffers against problems in the future. In my view EMDR played a significant part. The children all said that they used aspects of EMDR outside of the therapy situation and that this helped them to feel more confident and less anxious. They talked about using these techniques which were based on bilateral stimulation. The told me about their use in particular situations such as when practising for a play or before diving into the swimming pool and they related their success in these situations to the techniques from EMDR.

The method that I devised for this intervention drew from both SFBT and EMDR. I conclude from my reflections on this process that both of these therapies contributed to the outcome. The approaches have a number of similarities (see chapter 3) that lead to their compatibility. Both are aimed at helping people to experience their situation differently. Both focus on helping the person to function better in life outside the therapeutic sessions. SFBT and EMDR come from different therapeutic perspectives which lead to differences in how the procedures are delivered. Yet, set up and delivered in an integrated way they both appeared to add something to the lives of the children in this study. Shapiro (2001) makes the point that EMDR has moved from a simple technique to an integrated psychotherapy approach. Shapiro's view is that it is in this synthesis that clients can be best served. She asserts that 'the emphasis

is not solely on the elimination of overt suffering, but also on attention to the comprehensive clinical picture that incorporates multifaceted personal growth and integration into the wider social systems' (Shapiro, 2001, p.x). My research was in keeping with this view. The therapy used an integrated approach drawing on EMDR and SFBT. The underlying aim of the therapy was to pay attention to personal growth and to the development of inner resources to support the children; in positive psychology terms, 'to build what is right'.

7.7.1 Did I achieve what I set out to achieve?

This research was not intended to be a dismantling study examining the individual elements of the therapy in an attempt to identify the effects of the component parts of the process. Therefore it is not possible to evidence the parts that made a difference. The study was an experiential approach. My interpretation of the process, based on my own experience and the feedback and reports of the children who took part, leads me to conclude that in a way the whole was greater than the parts. To consider the efficacy of the different components of SFBT and EMDR in a combined approach such as this would require further investigation. The framework of solution focused brief therapy was used to support the process. EMDR was used to strengthen positive resources. The purpose of this study was to reveal the children's accounts/stories of engaging with the process and to explore the nature of the experience. The study also considered the impact of the combined therapy from the point of view of the children. I wanted to gain an understanding of the views

and feelings of the participants and to explore my own experiences as the therapist and facilitator of this therapeutic intervention. In my view, I achieved this aim. The qualitative methodology provided the exploratory framework necessary to accommodate and embrace the social constructionist stance. The method captured the rich data from engagement with the children. IPA, the chosen method of analysis, provided an appropriate method to understand the experiences of the children in this study. The intervention was delivered within a group setting. It would have been simpler as the therapist and facilitator to have used this combined therapeutic approach with an individual child. However, I wanted to consider its use as an approach to address the needs of more than one child at a time. There was a need, therefore, to personalise the therapy to the individuals within a group setting. This was important from an ethical point of view. The therapeutic needs of each child remained paramount in the decision making process. It was also essential to personalize the therapy as the target for improvement for each child had been individually chosen by that child and as such the process was operating on different targets for each child within the group setting. The flexible research design was necessary to meet this purpose.

My research was located in professional practice and it is hoped that the findings contribute to the future work of an educational psychologist. The current financial climate requires educational psychologists to consider best value when delivering their work within a local authority service. This way of

working can offer a useful therapeutic intervention to a number of children, with the proviso that the educational psychologist has the appropriate professional training in EMDR and upholds the British Psychological Society Code of Ethics and Conduct (March 2006).

The additional support needs of the children in this study were at a level which would not normally reach the priority for referral to a specialist service such as psychological service due to pressure of demands in a school. Yet, they were such that they were likely to have continued to affect the children as they moved through primary school and into secondary. They may have resulted in more serious concerns at a later date. The intervention was in line with Seligman's view, as stated in chapter 1 of this thesis.

Psychology is not just about the study of pathology, weakness and damage; it is also the study of strength and virtue. Treatment is not just fixing what is broken; it is nurturing what is best (Seligman, 2000).

The values and research findings emerging from positive psychology indicate that there are human strengths which act as buffers against serious problems and these can be fostered in children. My work could be described as early intervention. If the positive outcomes reported by the children and corroborated by their parents and teachers continue, then this would seem to be an effective and efficient way of working and may in the longer-term reduce the likelihood

of such children reaching a priority level for a specialist service in the future. If the children have a greater sense of being able to accomplish things then this may act as a buffer in the future. Research indicates a significant positive relationship between self-efficacy and persistence on academic tasks (Multon, Brown and Lent 1991). People who have a sense of self-efficacy bounce back from failures; they approach things in terms of how to handle them rather than worrying about what can go wrong (Bandura 1988).

The study was not designed to measure longer term outcomes. Any future replication could include a follow-up study to measure the continued effect of such an approach. This was a small-scale practitioner based research study. The findings are based on a small number (5) of children. Therefore, it is not possible to draw general conclusions. However, very little research has been done in this area. The children in this study talked about feeling more confident. The therapy appeared to provide them with the belief that they could succeed. They were able to describe how the experience had made a difference in their lives and they were able to see a more positive future. The Review of Provision of Educational Psychology in Scotland (2002) makes the following point.

Psychologists' skills in dealing with vulnerable children and young people, their knowledge of preventative and early approaches, their familiarity with research and development methods and solution-focused measures will be fully utilised in the Government's vision for social inclusion in Scotland (p.63).

PAGE NUMBERING AS ORIGINAL

Finally, I leave the reader with the words of one of the children whose words express the impact of the therapy better than my own.

'See being here, it feels like my world is falling into place.'

(child 5)

References

Allport, G.W. (1962). The general and the unique in psychological science. *Journal of Personality, 30,* 405-422.

American Psychological Association (1995). *Task Force on Psychological Procedures. Division 12 (Clinical Psychology).*

Andrade J.; Kavanaugh, D.B.A.(1997). Eye movement and visual imagery: A working memory approach to the treatment of post-traumatic stress disorder. *British Journal of Clinical Psychology, 36,* 209-223.

Arkowitz, H. (1992). Integrative theories of therapy. In D. K. Freedheim (Ed.), *History of psychotherapy: A century of change.* Washington, DC . US: American Psychological Association.

Armstrong, M.S. and Vaughan, K. (1996). An orienting response model of eye movement desensitization. *Journal of Behavior Therapy and Experimental Psychiatry, 27,* 21-32.

Armstrong, R. (2007). *Traumatised children's experience of Eye Movement Desensitization and Reprocessing (EMDR) therapy: A Qualitative Study.* Unpublished doctoral thesis. Canterbury Christ Church University.

Artigas, L., Jarero, I., Mauer, M., Lopez Cano, T. and Alcala, N. (2000).*EMDR and traumatic stress after natural disasters: Integrative treatment protocol and the butterfly hug.* Poster presented at the EMDRIA Conference, Toronto, Ontarion, Canada.

Bandler, R. Grinder, J. (1975). *The Structure of Magic.* California: Science & Behavior Books, Inc.

Bandura, A. (1988). Perceived self-efficacy: Exercise of control through self-belief. In J. P. Dauwalder, M. Perrez, & V. Hobi (Eds.), *Annual series of European research in behavior therapy, 2,* 27-59. .Lisse, The Netherlands: Swets & Zeitlander.

Bandura, A. (1997). *Self-Efficacy in Changing Societies.* Cambridge, UK: Cambridge University Press.

Barlow, D.H. Hayes, S.C. and Nelson, R.O. (1984). *The Scientist Practitioner: research and accountability in clinical and educational settings.* New York: Pergamon.

Barrowcliff, A., Gray, N., MacCulloch, S., Freeman, T. and MacCulloch, M. (2003). Horizontal rhythmical eye movements consistently diminish the arousal provoked by auditory stimuli. . *British Journal of Clinical Psychology 42(3),* 289-302.

Bateson, G. (1972). Steps to an Ecology of Mind: Collected Essays. In *Anthropology, Psychiatry, Evolution and Epistemology.* Chicago: University of Chicago Press.

Bateson, G. (1979). *Mind and Nature: A Necessary Unity (Advances in Systems Theory, Complexity, and the Human Sciences).* New York: E.P. Dutton.

Berg, I.K. (1991). *Family Preservation: A Brief Therapy Workbook.* London: BT Press.

Berg, I.K. (1994). *Family based services: a solution-focused approach.* New York: W. W. Norton.

Berg, I.K. and De Jong, P. (1996). Solution-building conversations: co-constructing a sense of competence with clients. *Families in Society, 77,* 376-391.

Bergmann, U. (1998). Speculations on the neurobiology of EMDR. *Traumatology, 4, 2,* Article 2.

Bergmann, U. (2000). Further Thoughts on the Neurobiology of EMDR: The Role of the Cerebellum in Accelerated Information Processing. *Traumatology, 6,* 175-2000.

Beybach, M., Rodriguez Sanchez, M.S., Arribas de Miguel, J., Herrero de Vega, M., Herrnadez, C. and Rodriguez-Morejon, A. (2000). Outcome of solution-focused therapy at a university therapy center. *Journal of Systemic Therapies, 19,* 116-128.

Bien, T. (2006). Mindful Therapy: A Guide for Therapists and Helping Professionals. Boston: Wisdom Publications.

Bronfenbrenner, U. (1979). *The Ecology of Human Development.* Cambridge: Harvard University Press.

Brown, A. and. Dowling, P. (1998). *Doing Research/Reading Research: A Mode of Interrogation for Education.* London: Falmer Press.

Burnett, P.C. (1998). Behavioural Indicators of Self-Esteem (BIOS). In N. Frederickson and R.C. Cameron (Eds.) *Psychology in Education Portfolio.* Berkshire: NFER-NELSON.

Burnett, P.C. (1994). Burnett Self-Scale (BSS). In N. Frederickson and R.C. Cameron (Eds.) *Psychology in Education Portfolio*. Berkshire: NFER-NELSON.

Burr, V. (1995). *An introduction to social constructionism.* London: Routledge.

Burr, V. (2003). *Social constructionism.* London: Routledge.

Burr, W. (1993). Evaluation der Anwendung Losungsorientierer Kurztherapie in einder kinder-und jugendpsychiartischen Praxis (Evaluation of the use of brief therapy in a practice for children and youths). *Familiendynamik, 18*, 11-21 (German; abstract in English).

Carlson, J.G., Chemtob, C., Rusnak, K., Hedlund, N. and Muraoka, M. (1998). Eye Movement Desensitization and Reprocessing (EMDR) treatment for combat-related posttraumatic stress disorder. *Journal of Traumatic Stress, 11*, 3-24.

Chemtob, C.M. and Nakashima, J. (1996). Eye movement desensitization and reprocessing (EMDR) Treatment for children with treatment resistant disaster related distress. *Paper presented at the annual meeting of the International Society for Traumatic Stress Studies.* San Francisco: CA November.

Chemtob, C.M. Tolin, D.F., van der Kolk, B.A. & Pitman, R.K. (2000).Eye movement desensitization and reprocessing. In E. B. Foa, T.M. Keane, &M.J. Friedman (Eds.) Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress (pp.139-335). New York: Guilford Press.

Chemtob, C.M., Nakashima, J., Hamada, R. & Carlson, J.G. (2002). Brief treatment for elementary school children with disaster-related PTSD: A field study. *Journal of Clinical Psychology, 58,* 99-112.

Cockburn, J.T., Thomas, F.N. and Cockburn, O.J. (1997). Solution-focused therapy and psychosocial adjustment to orthopedic rehabilitation in a work hardening program. *Journal of Occupational Rehabilitation, 7(2),* 97-106. Netherlands: Springer.

Cohen, L., Manion, L. (1994). *Research Methods in Education*. London: Routledge and Kegan Paul.

Cohen, L., Manion, L. & Morrison, K. (2008). *Research Methods in Education*. London: Routledge Taylor Francis Group.

Conrad, P. (1987). The experience of illness: recent and new directions. *Research in the Sociology of Health Care,* 6, 1-31. Amsterdam: Elsevier Science.

Cook, T.D. and Campbell, D.T. (1979). *Quasi-Experimentation: Design and Analysis Issues for Field Settings.* Chicago, Illinois: Rand McNally.

Corey, G. (1996) *Theory and Practice of Counseling and Psychotherapy (5th ed.).* Pacific Grove, CA: Brooks/Cole.

Craig, C. (2007). *Creating Confidence.* Glasgow: The Centre for Confidence and Well-being.

Cruz, J. and Littrell, J.M. (1998). Brief Counseling with Hispanic American college students. *Journal of Multicultural Counseling and Development.* 26, 227-238.

Daniels, N. Lipke, H. Richardson, R. and Silver, S. (1992). *Vietnam veterans' treatment programs using eye movement and reprocessing.* Symposium presented at the International Society for Traumatic Stress Studies annual convention. Los Angeles, CA.

Danner, D. Snowdon, D. & Friesen, W. (2001). Positive emotions in early life and longevity: Findings from the nun study. *Journal of Personality and Social Psychology.* 80. 804-813.

Danziger, K. (1997). *Naming the mind: How psychology fond its language.* London: Sage.

Davie, R. (1996) Introduction: Partnership with Children: The Advancing Trend. In R. Davie, G. Upton and V. Varma (Eds.) *The Voice of the Child.* London: The Falmer Press.

De Jong and Berg, I.K. (2002). *Interviewing for Solutions.* Pacific Grove: Brooks Cole.

De Jong, P. and Hopwood, L.E. (1996). Outcome research on treatment conducted at the Brief Family Therapy Center 1992-1993, in S.D. Miller, M.A.Hubble, M.A. and B.L. Duncan (Eds) *Handbook of Solution-focused Brief Therapy.* San Francisco: Jossey-Bass. pp. 272-298.

de Shazer, S. (1985). *Keys to solution in brief therapy.* New York: Norton.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: Norton.

de Shazer, S. (1991). *Putting difference to work.* New York: Norton.

de Shazer, S., Berg, I.K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: focused solution development. *Family Process, 25,* 207-222.

de Shazer, S. and Berg, I.K. (1997). 'What works': remarks on research aspects of solution-focused brief therapy. *Journal of Family Therapy, 19(2),* 121-124.

Deal, R. (2003). *Strength Cards for Kids.* Victoria, Australia: Innovative Resources.

Deci, E.L. ad Ryan, R.M. (1995). Human autonomy: the basis for true self-esteem. In M.H. Kernis, (Ed.) Efficacy, Agency and Self-esteem. New York: Plenum Press.

Dunton, R. (1999). Application of EMDR in the learning process. Paper presented at the Fourth World Congress on Behavior Therapy, Queensland, Australia. Abstract retrieved 15.07. 2008 from http://library.nku.edu/emdr/emdr3

Durrant, M. (1992). *A Solution-Focused Approach to Work With Children, Adolescents and Families,* two-day workshop, October 1992. Unpublished notes.

Durrant, M. (1993). *Creative Strategies for School Problems.* Alexandria, Australia: Bell Graphics.

EMDR Europe. *Research and Evidence Base for EMDR.* Retrieved 13 December 2009 from emdr-europe.org/research.htm

Etherington, K. (2004). *Becoming a Reflexive Researcher.* London: Jessica Kingsley Publishers.

Feske, U. (1998). *Eye movement desensitization and reprocessing for posttraumatic stress disorder. Clinical Psychology: Science and Practice, 5,* 171-181.

Finlay, L. (2005). Reflexive embodied empathy: a phenomenology of participant-researcher intersubjectivity, *Methods Issue: The Humanistic Psychologist, 33(4),* 271-292.

Forte, K. (1999).*The EMDRIA Newsletter, 4(4),* 20-22.

Fox, M., Martin, P. & Green, G. (2007). *Doing Practitioner Research.* London: SAGE Publications Ltd.

Frederickson, B.L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *Journal of American Psychological Association, 54(3),* 218-226.

Frederickson, N. (2002). Evidence-based practice and educational psychology. *Educational and Child Psychology, 19*(3), 96-111.

Gergen, K.J. and Gergen, M.M. (1984). The social construction of narrative accounts. In K.J. Gergen & M.M. Gergen (Eds.), *Historical Social Psychology.* Hillsdale, N.J: Laurence Erlbaum Associates.

Gergen, K.J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40,* 266-275.

Gergen, K.J. (1994). Exploring the postmodern. Perils or potentials? *American Psychologist, 49,* 412-416.

Gergen, K.J. (1999). *An invitation to social construction.* London: Sage.

Gillham, B. (1978). Directions of Change. In *Restructuring Educational Psychology.* Gillham, B. (Ed.). Pp 11-23. Croom Helm Ltd: London.

Gingerich, W. J. and Eisengart, S. (2000). Solution-focused brief therapy: a review if the outcome research. *Family Process, 39,* 477-498.

Gingerich, .J. and Eisengart, S. (2001). Retrieved 12 September 2006 from www.gingerich.net

Grandison, P. (2007). A combined approach: Using EMDR within a framework of solution focused brief therapy. *Educational & Child Psychology, 24*(1), 56-64.

Greenwald, R. (1994). Applying eye movement desensitization and reprocessing (EMDR) to the treatment of traumatized children: Five case studies. *Anxiety Disorders Practice Journal,* 1, 83-97.

Greenwald, R. (1998). Eye movement desensitization and reprocessing (EMDR): New hope for children suffering from trauma and loss. *Clinical Child Psychology and Psychiatry, 3,* 279-287.

Greenwald, R. (2001). *Eye Movement Desensitization and Reprocessing (EMDR) In Child and Adolescent Psychotherapy.* New Jersey: Jason Aronson inc.

Grinder, J., Delozier, J. and Bandler, R. (1997) *Patterns of the Hypnotic Techniques of Milton H. Erickson, Md. Vol. 2.* Cupertino, California: Met.

Haley, J. (1993). *Uncommon Therapy.* New York: W. W. Norton & Company.

Herbert, J.D., Lilienfeld, S.O., Lhor, J.M., Montgomery, R.W., O'Donohue, W.T., Rosen, G.M. & Tolin, D.F. (2000). Science and pseudoscience in the development of eye movement desensitization and reprocessing. Implications for clinical psychology. *Clinical Psychology Review, 20,* 945-971.

Hick, S.F. Cultivating Therapeutic Relationships: The Role of Mindfulness. In, Hick, S.F. and Bien, T. (Eds.) (2008). Mindfulness and the Therapeutic Relationship. London: The Guilford Press.

Hollon, S.D. (1999). Allegiance effects in treatment research. A commentary. *Clinical Psychology. Science & Practice, 6,* 107-112.

Ironson, G., Freund, B., Strauss, J.L. and Williams, J. (2002). Comparison of Two Treatments for Traumatic Stress: A Community-Based Study of EMDR and Prolonged Exposure. *Journal of Clinical Psychology, 58(1),* 113-128.

Iveson (1990). *Whose Life? Working with Older People.* London: BT Press.

Jaberghaden, N., Greenwald, R., Rubin, A., Zand, S.O. and Dolatabdi, S. (2004) A comparison of CBT and EMDR for sexually-abused Iranian girls. *Journal of Clinical Psychology and Psychotherapy, 11(5),* 358-368.

Jarero, I., Artigas, L. and Hartung, J. (2006). EMDR Integrative Group Treatment Protocol: A Postdisaster Trauma Intervention for Children and Adults. *Traumatology, 12*(2), 121-129.

Kabat-Zinn, J. (1994). Wherever you go, there you are: Mindfulness meditation in everyday life. New York: Hyperion.

Kelly, G.A. (1955). *The Psychology of Personal Constructs. Vol.1. A theory of personality.* New York: W.W. Norton.

Kelly, G.A. (1986). *A Brief Introduction to Personal Construct Theory.* London: Centre for Personal Construct Psychology.

Kernis, M.H. (ed.) (1995). *Efficacy, Agency and Self-esteem.* New York: Plenum Press.

Kidder and Fine, (1987). Qualitative Inquiry in Psychology: A Radical Tradition. In D. Fox & I. Prilleltensky (Eds.). *Critical Psychology: An Introduction.* London: Sage Publications.

Knekt, P. and Lindors, O. (2004). A randomised trial of the effect of our forms of psychotherapy on depressive and anxiety disorders: design, methods and results on the effectiveness of short-term psychodynamic psychotherapy and solution-focused therapy during a one-year follow-up. *Studies in Social Security and Health, No. 77.* The Social Insurance Institution, Helsinki, Finland.
(www.*kela.fi/research)*

Korn, D. & Leeds, A. (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *Journal of Clinical Psychology, 58,* 1465-1487.

Kral, (1987) *Strategies that Work: Techniques for Solutions in the Schools*. Milwaukee: BFTC.

LaFountain, R.M. & Garner, N.E. (1986). Solution-focused counselling groups: the results are in. *Journal for Specialists in Group Work, 21,* 128-143.

Lambert, M.J. and Simon, W. The Therapeutic Relationship: Central and Essential in Psychotherapy Outcome. In, Hick, S.F. and Bien, T. (Eds.) (2008). Mindfulness and the Therapeutic Relationship. London: The Guilford Press.

Langridge, D. (2004). *Introduction to Research Methods and Data Analysis in Psychology.* Essex: Pearson Education Limited.

Lee, M.Y. (1997). A study of solution-focused brief family therapy: Outcomes and issues. *American Journal of Family Therapy, 25,* 3-17.

Leeds, A. (1998). Lifting the burden of shame: Using EMDR resource installation to resolve a therapeutic impasse. In P. Manfield (Ed.) *Extending EMDR: A case book of innovative applications.* New York: Norton.

Leeds, A. and Shapiro, F. (2000). EMDR and Resource Installation: Principles and procedures for enhancing current functioning and resolving traumatic experiences. In J. Carlson & L. Sperry (Eds.), *Brief Therapy Strategies with Individuals and Couples*. Pheonix, Arizona: Tucker, Zeig, Theisen, Inc. Publishers.

Lines, D. (2002). *Brief Counselling in Schools.* London: Sage.

Lindforss, L. and Magnusson, D. (1997). Solution-focused therapy in prison. *Contemporary Family Therapy, 19,* 89-104.

Lipke, H. (1995). EMDR clinicians survey. In F. Shapiro. *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures.* New York: Guilford.

Lipke, H. (2000). *EMDR and Psychotherapy Integration: theoretical and clinical suggestions with focus on Traumatic stress.* New York: CRC Press.

Lohr, J., Tolin, D. and Lilienfeld, S. (1998). Efficacy of eye movement desensitization and reprocessing: Implications for behavior therapy. *Behavior Therapy 29,* 123-156.

Lovett, J. (1997). *EMDR with children: Treating "cascades of trauma" in a young child.* Paper presented at the EMDR International Association Conference, Denver, Co.

Lovett, J. (1999). *Small Wonders. Healing Childhood Trauma with EMDR.* New York: The Free Press.

Macdonald, A. (2007). *Solution-Focused Therapy Theory, Research & Practice.* London: Sage Publications Limited.

McCann, D.L. (1992). Post-traumatic stress disorder due to devastating burns overcome by a single session of Eye Movement Desensitization. *Journal of Behavior Therapy and Experimental Psychiatry, 23,* 319-323.

McKeel, A.J. (1996) A clinician's guide to research on solution-focused therapy. In S.D. Miller, M.A.Hubble and B.L. Duncan (Eds.). *Handbook of Solution-focused Brief Therapy.* San Francisco: Jossey-Bass.

McKeel, A.J. (1999) *A selected review of research of solution-focused brief therapy.* Retrieved 21 May 2006 from www.enabling.org/ia/sft

McLean, A. (2004). *The Motivated School.* London: Paul Chapman Publishing.

Marcus, S., Maquiis, P. & Sakai, C. (1997). Controlled study of treatment of PTSD using EMDR in an HMO setting. *Psychotherapy, 34,* 307-15.

Maxfield, L. and Hyer, L. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology, 58(1)*, 23-41.

Montgomery, R.W. and Ayllon, T. (1994). Eye movement desensitization across subjects: Subjective and physiological measures of treatment efficacy. *Journal of Behavior Therapy and Experimental Psychiatry, 25,* 217-230.

Morris, E. (2002). *An Emotionally Literate Approach to Anger Management.* Milton Keynes: Incentive Publishing.

Morris, E. (2002). Self-Esteem Indicator: Primary. *Insight Primary Assessing and Developing Self-Esteem.* London: nferNelson.

Morrison, J.A., Olivos, K., Dominguez, G., Gomez, D. and Lena, D. (1993). The application of family systems approaches to school behaviour problems on a school-level discipline board: an outcome study. *Elementary School Guidance & Counselling, 27,* 258-272.

Multon, K.D., Brown, S.D. and Lent, R.W. (1991). Relation of self-efficacy beliefs to academic outcomes: A meta-analytical investigation. *Journal of Counseling Psychology, 38,* 30-38.

Newsome, W.S. (2005). The impact of solution-focused brief therapy with at risk junior high school students. *Children & Schools, 87,* 83-91.

National Institute for Clinical Excellence (NICE) *Guidelines for the Treatment of Post Traumatic Stress Disorder (PTSD).* (2005). www.nice.org.uk

Norcross, J.C. and Newman, C.F. (1992). Psychotherapy Integration: Setting the context. In J.C. Norcross & M.R. Goldfried (Eds.) *Handbook of psychotherapy integration.* New York: Basic Books.

O'Connell, B. (1998). *Solution-focused therapy.* London: Sage.

O'Hanlon, B. & Beadle, S. (1997). *A Field Guide to Possibilityland. Omaha, NE: Norton.*

O'Hanlon, B. & Weiner-Davis, M. (1989). *In Search of Solutions: A New Direction in Psychotherapy.* New York: W W Norton & Co.

Oswalt, R., Anderson, M., Hogstrom, K. and Berkowitz, B. (1993). Evaluation of the one-session eye-movement desensitization

reprocessing procedure for eliminating traumatic memories. *Psychological Reports, 73,* 99-104.

Perkins, B.R. and Rouanzoin, C.C. (2002). A critical evaluation of current views regarding eye movement desensitization and reprocessing (EMDR): Clarifying points of confusion. *Journal of Clinical Psychology, 58,* 77-97.

Perry, B.D. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind, 3,* 79-100.

Perry, B.D. (2009). Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. *Journal of Loss and Trauma, 14,* 240-255.

Peterson, C. and Seligman., M.E.P. (2004). *Character Strengths and Virtues.* New York: Oxford University Press.

Pidgeon, N. (1996). Grounded theory: theoretical background. In J.E. (Ed.) *Handbook of Qualitative Research Methods for Psychology and the Social Sciences.* Leicester: British Psychological Society.

Puffer, M. K., Greenwald, R. and Elrod, D.E. (1998). A single session EMDR study with twenty traumatizes children and adolescents. *Traumatology, 3(2).*

The British Psychological Society *Code of Ethics and Conduct* (March 2006). Leicester: British Psychological Society.

Reason, P. (2003). Doing Co-operative Inquiry. In J. Smith. (Ed.) *Qualitative Psychology: A Practical Guide to Methods.* .London: Sage Publications.

Rees, I. (2005). *Solution Focused Brief Therapy as Perceived by Educational Psychologist and Adolescent Client.* Doctoral thesis, University of Wales.

Renfrey, G. and Spates, C.R.. (1994). Eye movement desensitization and reprocessing: A partial dismantling procedure. *Journal of Behavior Therapy and Experimental Psychiatry, 25,* 231-39.

Rhodes, J. and. Ajal, Y. (2004). *Solution Focused Thinking in Schools.* London: BT Press.

Robson, C. (1993). *Real World Research. A Resource for Social Scientists and Practitioner-Researchers.* Oxford: Blackwell.

Robson, C. (2002). *Real World Research. A Resource for Social Scientists and Practitioner-Researchers (2nd edn).* Oxford: Blackwell Publishing.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 22, 95-103.

Rogers, C. R. (1991). *A Client-Centred Therapy.* London: Constable.

Rothbaum, B.O. (1997). A controlled study of eye movement desensitization and reprocessing in the treatment of post-traumatic stress disordered sexual assault victims. *Bulletin of the Menninger Clinic, 61,* 317-334.

Rutter, M. (1999a) Emmanuel Miller lecture, 1998. *Journal of Child Psychology and Psychiatry. 40,* 169-188.

Rutter, M. (1999b) Revised Rutter Parent Scale for School-Age Children. In *Child Psychology Portfolio 3.* Berkshire: nferNelson.

Sarti, J.P. (2003). *A hermeneutic interpretation of solution-focused therapy: the interweaving of historical time and theory.* PsyD, Alliant International University, San Francisco Bay.

Scheck, M.M., Schaeffer, J.A. & Gillette, C.S. (1998). Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. *Journal of Traumatic Stress, 11,* 25-44.

Schorr, M. (1997). Finding solutions in a roomful of angry people. *Journal of systemic therapies, 16,* 201-210.

Scottish Executive Education Department. (2004) *A Curriculum for Excellence, the curriculum review group.* Glasgow: Learning and Teaching Scotland.

Scottish Executive Education Department. (2001). *For Scotland's children report.* Edinburgh: Scottish Executive.

Scottish Executive Education Department. (2002). *Review of Provision of Educational Psychology Services in Scotland (Currie Report).* Edinburgh: Scottish Executive Publication.

Scottish Executive Education Department. (2004). *Additional Support for Learning (Education) (Scotland) Act.* Edinburgh: Scottish Executive.

Scottish Government. (2008). *A Guide to Getting it Right for Every Child.* Retrieved 21 January 2009 from www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec

Scottish Government (2009). *A Curriculum for Excellence.* Edinburgh: Scottish Government.

Seagram, B.C. (1997). The *efficacy of solution-focused brief therapy with young offenders.* Unpublished doctoral thesis, York University, New York, Ontario, Canada.

Seidler, G. & Wagner, F. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD. A meta-analytic study. *Psychological Medicine, 36,* 1515-1522.

Seligman, M.E.P. (1995). *The Optimistic Child.* Boston: Houghton Mifflin Company.

Seligman, M.E.P. (1998). *Building human strength: psychology's forgotten mission.* Retrieved 18 October 2009 from apa.org/monitor/jan98/pres.html

Seligman, M.E.P. (2001). *Positive Psychology.* Paper presented at Future Visions, State of the World Forum, New York: retrieved 6 January 2010.

Seligman, M. and Csikszentmihalyi, M. (2000). Positive psychology: An Introduction. *American Psychologist, 55,* 5-14.

Servan-Schreiber, D. (2000). Eye movement desensitization and reprocessing. Is psychiatry missing the point? *Psychiatric Times, 17,* 36-40.

Shapiro, F. (1991). Stray thoughts. *EMDR Network Newsletter,* pp.1-3

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress Studies, 2,* 199-223.

Shapiro, F. (1994). Alternative stimuli in the use of EMDR. *Journal of Behavior Therapy and Experimental Psychiatry, 25,* 89.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing. Basic principles, protocols and procedures.* New York: Guilford Press.

Shapiro, F. (1999). EMDR and the anxiety disorders: Clinical and research implications of an integrated psychotherapy treatment. *Journal of Anxiety Disorders, 13,* 35-67.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing (EMDR) Basic Principles, Protocols, and Procedures.* New York: The Guilford Press.

Shapiro, F. and Forrest, M. S. (1997). *EMDR: The Breakthrough Therapy For Overcoming Anxiety, Stress, And Trauma.* New York: Basicbooks.

Sharry, J. (2001). *Solution-Focused Groupwork.* London: Sage Publications.

Sherif, M. (1966). *In common predicament: Social psychology of intergroup conflict and cooperation.* Boston: Houghtn-Miffin.

Smith, J. A. and Osborn., M. (2003). Interpretive phenomenological analysis. In J.
Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods.* London: SAGE Publications Ltd.

Smith, J. A. and Osborn., M. (2004). Interpretive phenomenological analysis. In G. Breakwell (Ed.) *Doing Social Psychology*, pp.229-254.

Soberman, G., Greenwald, R. & Rule, D.L. (2002). A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment, and Trauma, 6,* 217-236.

Soloman, S.D., Gerrity, E.T. & Muff, A.M. (1992). Efficacy of treatments for posttraumatic stress disorder. *JAMA, 268,* 633-638.

Soloman, R.M. and Shapiro, F. (1997). Eye movement desensitization and reprocessing: A therapeutic tool for trauma and grief. In C.R. Figley, B.E. Bride & N. Mazza (Eds.) *Death and trauma. The traumatology of grieving* (pp.231-247). Washington, DC: Taylor and Francis.

Spector, J. and Read, J. (1999). The current status of eye movement desensitization and reprocessing (EMDR). *Clinical Psychology and Psychotherapy, 5,* 126-144.

Springer, D.W., Lynch, C. and Rubin, A. (2000). Effects of a solution-focused mutual aid group for Hispanic children of incarcerated parents. *Child and Adolescent Social Work, 17,* 431-442.

Stickgold, R. (2002). A putative neurobiological mechanism of action. *Journal of Clinical Psychology, 58(1),* 61-75.

Stobie, I., Boyle, J. and Woolfson, L. (2005). Solution-Focused Approaches in the Practice of UK Educational Psychologists. A Study of the Nature of Their Application and Evidence of their Effectiveness. *School Psychology International, 26(1),* 5-28. London: Sage Publications.

Stoddart, K.P., McDonnell, J., Temple, V. and Mustate, A. (2001). Is brief better? A modified brief solution-focused therapy approach for adults with a developmental delay. *Journal of Systemic Therapies, 20,* 24-41.

Sundstrom, S.M. (1993). *Single-session psychotherapy for depression: Is it better to focus on problems or solutions?* Unpublished doctoral dissertation. Iowa State University, Ames IA.

Taylor, S. (2003). Outcome predictors for three PTSD treatments: exposure therapy, EMDR, and relaxation training. *Journal of Cognitive Psychotherapy, 17(2),* 149-161.

Taylor, S., Thorarsn, D., Maxfield, L., Federoff, I., Lovell, K. & Ogrodciczuk, J. (2003).Comparative efficiency, speed and adverse effects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. *Journal of Consulting and Clinical Psychology, 71,* 330-338.

Teasdale, J.D. (1999). Emotional processing, three modes of mind and the prevention of relapse in depressión. Behaviour Research and Therapy, 37(suppl. 1), 53-77.

Thomson, R. & Littrell, J.M. (2000). Brief Counseling with learning disabled students. *The School Counselor, 2,* 60-67.

Tinker, R. H. and Wilson, S.A. (1999). *Through the Eyes of a Child EMDR with Children.* New York: W. W. Norton and Company.

Tuckman, B.W. and Sexton, T.L. (1990). The relation between self-beliefs and self-regulated performance. Journal of Social Behaviour and Personality, 5, 465-72.

United Nations Convention on the Rights of the Child *(article 12),* (1989).

Van der Kolk, B.A., Spinazzola, J., Blaustein, M.E., Hopper, J.W., Hopper, E.K., Korn, D.L. and Simpson, W.B. (2007). A Randomized Clinical Trial of Eye Movement Desensitization and Reprocessing (EMDR), Fluoxetine, and Pill Placebo in the treatment of Posttraumatic Stress Disorder: Treatment Effects and Long-Term Maintenance. *Journal of Clinical Psychiatry, 68(1),* 37-46.

Walter, L.J. and Peller, E.J. (1992). *Becoming Solution-focused in Brief Therapy.* New York: Brunnel/Mazel.

Walzlawick, P., Weakland, JH. and Fisch, R. (1974). *Change: Principles of Problem, Formation and Problem Resolution.* New York: Norton.

Warnock Report (1978). *Special educational needs: Report of the Committee of Enquiry into the education of handicapped children and young people.* London: HMSO.

White, M. and Epston, D. (1990). *Narrative Means to Therapeutic Ends.* New York: W. W. Norton & Company, Inc.
White, M. and Epston, D. (1992). *Experience, contradiction, narrative and imagination: selected papers of David Epston & Michael White. 1989-19.* Adelaide, South Austraiia: Dulwich Centre Publications.

Willig, C. (2001). *Introducing Qualitative Research in Psychology.* Buckingham: Open University Press.

Wilmhurst, L.A. (2002). Treatment Programs for Youth With Emotional and Behavioral Disorders: An Outcome Study of Two Alternate Approaches. *Mental Health Services Research, 4,* 2.

Wilson, S.A., Becker, L.A. & Tinker, R.H. (1997). 15 month follow-up of eye movement desensitization and reprocessing (EMDR) treatment for psychological trauma. *Journal of Consulting and Clinical Psychology, 65(6),* 1047-1056.

Zabukovec, J. Lazrove, S. and Shapiro, F. (2000). Self-healing aspects of EMDR: The therapeutic change process and perspectives of integrated psychotherapies. *Journal of Psychotherapy Integration, 10(2),* 189-206.

Zimmerman, T.S., Jacobsen, R.B., MacIntyre, M. and Watson, C. (1996). Solution-focused parenting groups: an empirical study. *Journal of Systemic Therapies. 15,* 12-25.

Zimmerman, T.S. Prest, L.A., and Wetzel, B.E. (1997) Solution-focused couples therapy groups: an empirical study. *Journal of Family Therapy, 19,* 125-144.

Statutory material:

Additional Support for Learning (Education) (Scotland) Act 2004.
Education (Scotland) Act 1980.
Education Act, (1981).
Social Work (Scotland) Act 1968.
The Standards in Scotland's Schools etc. Act 2000.

Appendices

1. Matrix: Levels of work and core functions for Psychological Services in Scotland with exemplars of types of work for each of the 5 core functions
2. Information for parents
3. Information for children
4. Self-Esteem Indicator: Primary completed by teacher: child 2 (pre-sessions)
5. Behavioural Indicators of Self-Esteem (BIOS) completed by teacher: child 2 (pre-sessions)
6. Revised Rutter Parent Scale for School-Age Children: child 2 (pre-sessions)
7. Burnett Self Scale (BSS): child 2 (pre-sessions)
8. Session Aims
9. Reflections on the sessions
10. Semi-structured interview schedule (blank)
11. Transcript of semi-structured interview: child 2
12. Activities checklists: child 2
13. Notes taken at interview with teacher: child 2 (post-intervention)
14. Self-Esteem Indicator: Primary completed by teacher: child 2 (post-sessions)
15. Behavioural Indicators of Self-Esteem (BIOS) completed by teacher: child 2 (post-sessions)
16. Notes taken at interview with parent: child 2 (post-intervention)
17. Examples of quotations from interview transcripts
18. Comparison of statements made by teachers and parents pre the intervention
19. Comparison of statements made by teachers and parents post the intervention
20. Comparison of pre and post statements made by teachers
21. Comparison of pre and post statements made by parents
22. Drawing made by child 2 at closure meeting
23. Final comments made by children at the closure meeting

Appendix 1: ***Matrix: Levels of work and core functions for Psychological Services in Scotland with exemplars of types of work for each of the 5 functions***

3 LEVELS OF WORK	5 CORE FUNCTIONS FOR PSYCHOLOGICAL SERVICES (the core functions apply across each level)

	CONSULTATION	ASSESSMENT	INTERVENTION	TRAINING	RESEARCH
Child and family	Discussions with school staff and/or parents on strategies to support a child.	Contributing to a multi-agency assessment, use of dynamic assessment	Therapeutic work with individuals, input to group-work	Work with parents on strategies to manage behaviour, information on specific issues such as supporting reading	Evaluation of individual case-studies, follow-up on use of video interactive guidance (VIG)
School or establishment	Advice to school staff on learning or behaviour programmes	Involvement with senior management on policy developments,	Contribution to whole school initiatives, e.g. Solution Oriented School Programme, Development of Restorative Practices	Staff training in nurseries and schools, sharing good practice	Supporting action research
Education Authority/Council	Advice on resources for children with additional support needs, contribution to strategic planning, advice on legal aspects, e.g. Co-ordinated Support Plans (CSP	Evaluation of out of authority placements	Resource allocation, alternatives to exclusion..	Multi-agency training on new procedures, e.g. 'Getting it Right for Every Child', joint assessment and planning	Informing evidence based practice, contribution to design and implementation of authority wide research.

Appendix 1

MIDLOTHIAN COUNCIL

King's Park Primary School
20 Croft Street
Dalkeith
Midlothian
EH22 3BA

Headteacher Iain Dalglish

Tel 0131 663 2414
Fax 0131 663 2914

Dear

Mrs Grandison is looking forward to working with the small group of children over the coming weeks. She will also be in during your consultation evening this week, should you wish to meet her and gain any more information. Mrs Grandison will be based in the GP room at the end of the upper school corridor and would be pleased to meet with you informally, before or after the normal consultation with the class teacher.

Yours sincerely,

Headteacher
Monday 15 November 2004.

Psychological Services **Education**
Midlothian Council
Greenhall Centre
Gowkshill
Gorebridge
EH23 4PE

Director
Donald S Mackay

Midlothian

2b

19 May 2005

Mrs

Dear Mrs

You will remember that I said that I would make contact with you once I had completed the group work at Primary School. We held the final group session this week and I have spoken to each of the children involved about their experiences.

It would also be helpful for me to talk with you about the work that we did in the group and to discuss any changes that you may have noticed. I will contact you again in a couple of weeks to arrange a suitable time for this.

Yours sincerely

Pam Grandison

Pam Grandison
Senior Educational Psychologist

Your Ref:
Our Ref: PG/ns

Tel 01875 823500
Fax 01875 823603
www.midlothian.gov.uk

Psychological Services **Education**
Midlothian Council
Greenhall Centre
Gowkshill
Gorebridge
EH23 4PE

Director
Donald S Mackay

Midlothian

2c

11 July 2005

Mrs

Dear Mrs

I am writing to suggest a date for me to call to speak to you about the group work that took part in at school.

I could come to see you at home on Thursday 14th July at 3 o'clock. does not need to be there as I have already spoken to her about the work.

If this date is not suitable, would you please telephone me at 01875 823699 to arrange another time.

Yours sincerely

PG

Pamela Grandison
Senior Educational Psychologist
pamela.grandison@midlothian.gov.uk

Psychological Services **Education**
Midlothian Council
Greenhall Centre
Gowkshill
Gorebridge
EH23 4PE

Director
Donald S Mackay

Midlothian

2d

14 July 2005

Mrs

Dear Mrs

I hope you had a good holiday and enjoyed the sunshine.

I tried to telephone you today but unfortunately missed you so I thought it best to write to arrange to speak to you about any changes you have noticed since started the group work with me.

You mentioned that you go out to work at around 9.00am. I could come to see you for a brief chat before this if suitable, or if you prefer, it could be later in the day.

I suggest that I call round on Wednesday 20 July at 8.30am. I hope this suits you and look forward to meeting you. does not need to be present as I have already talked to him about the group work).

Yours sincerely

Pam Grandison
Senior Educational Psychologist

Your Ref:

Tel 01875 823500
Fax 01875 823603

Information provided verbally to children

- The group work will be carried out in school by Mrs Grandison who is an educational psychologist who visits the school

- The work is part of some research that Mrs Grandison is doing to see if this group work might be helpful for children.

- Some of the meetings will be recorded.

- After all the group meetings are over Mrs Grandison will meet each of you on your own to ask you some questions to find out what you thought about being part of this.

- You can change your mind at any time if you decide you do not want to keep coming to the group. Just let your parents or your teacher know or you can tell Mrs Grandison.

Appendix 4

Pre-sessions

nferNelson
understanding potential

Self-Esteem Indicator: Primary

Pupil's name: ..... Class: ..... Age: P5.

Administrator's name: .... Date: 1/12/04

Please answer all the questions. Circle the number to the right that you believe most accurately describes the pupil's situation/response to each question.

	Most of the time	Quite often	Occasionally	Almost never
1. If this pupil is encouraged, does s/he respond positively?	3	(2)	1	0
2. Is this pupil co-operative if something needs to be done or achieved?	3	(2)	1	0
3. Does this pupil usually enjoy and get on well with his/her work?	3	(2)	1	0
4. Does this pupil seem to be aware of what s/he is feeling (e.g. will this pupil tell you or show it if it is a strong feeling like excitement, anger or fear)?	3	2	(1)	0
5. Apart from you, does this pupil have significant adults who support and encourage him/her?	3	(2)	1	0
6. Does this pupil react reasonably if his/her school work is constructively criticised?	3	(2)	1	0
7. Do you feel interested/excited when you think of this pupil, rather than worried or annoyed?	3	2	(1)	0
8. Do other pupils like him/her?	3	(2)	1	0
9. Does this pupil enjoy having an opportunity to choose the activity s/he wants to do?	3	2	(1)	0
10. Can this pupil name some preferences and likes (e.g. food, friends, holidays, games, etc.)?	3	(2)	1	0
11. Has this pupil always got plenty to say to other people?	3	2	(1)	0
12. Does this pupil make a plan before attempting a task?	3	2	(1)	0
13. Can this pupil name his/her feelings (e.g. if you asked what s/he was feeling at some point in the day)?	3	(2)	1	0
14. Does this pupil like to play games with other pupils (e.g. games in pairs, sports teams, class quizzes, etc.)?	3	2	(1)	0
15. Does this pupil try something first before asking for help?	3	(2)	1	0
16. Can this pupil control his/her frustration and impatience?	3	(2)	1	0
17. Do other pupils often choose him/her to play with them?	3	(2)	1	0
18. Can this pupil read well for his/her age?	3	(2)	1	0
19. Does this pupil usually seem to be happy about things?	3	2	(1)	0
20. Does this pupil have any of the following – a best friend, a few close friends, a wide circle of friends?	3	(2)	1	0
21. Is this pupil independent, and does s/he like to do things his/her own way?	3	2	(1)	0
22. Is this pupil usually contented about things?	3	2	(1)	0
23. Does this pupil seem to get on well with you and other significant adults?	3	(2)	1	0
24. Does this pupil do sums well?	3	2	(1)	0
25. Does this pupil usually appear interested and curious about things?	3	2	(1)	0
26. Do you like this pupil?	3	(2)	1	0
27. Does this pupil like to look nice? (e.g. Have you seen this pupil tidying self up, or telling you about new clothes s/he has acquired, asking you to admire them?)	3	2	(1)	0
28. Is this pupil generally healthy?	3	(2)	1	0
29. Does this pupil initiate social activities relatively easily?	3	2	(1)	0
30. Can this pupil stand up for him/herself assertively rather than aggressively?	3	2	(1)	0
31. Does this pupil like to imagine being famous, powerful or extraordinary in some way (e.g. think of essays or roleplays s/he has done)?	3	2	1	(0)
32. Does this pupil spontaneously bring in objects, ideas or stories from home to share with the class?	3	2	1	(0)
33. Is this pupil reasonably competent at something s/he enjoys?	3	2	(1)	0
34. Does this pupil seem to like being a boy/girl (e.g. gets on well with the same sex friends and joins in with the more stereotypical masculine or feminine games fairly comfortably)?	3	(2)	1	0
35. Does this pupil comfortably make social overtures to a new pupil?	3	2	1	(0)
36. Does this pupil come over to you as being sure of her/himself?	3	2	1	(0)

Published by nferNelson Publishing Company Ltd, The Chiswick Centre, 414 Chiswick High Road, London W4 5TF, UK.

Overall self-esteem score ☐

Sense of self component score ☐

Sense of belonging component score ☐

Applicable 5

BEHAVIOURAL INDICATORS OF SELF-ESTEEM (BIOS)

RATING AND SCORING SHEET

NFER-NELSON
INFORMING YOUR DECISIONS

Pre-sessions

Student's Name .. .... Date 1/12/04

Teacher .... Class 5A

Directions: Please circle the response that best describes the frequency of this student's behaviour over the past two weeks in the school setting. Sum the responses and divide by 13 to obtain an average score.

	Never	Seldom	Sometimes	Often	Always
1. Was confident in what he/she did.	1	2	3	4	5
2. Was withdrawn from others.	5	4	3	2	1
3. Appeared proud of him/herself.	1	2	3	4	5
4. Gave limited responses.	5	4	3	2	1
5. Appeared happy with him/herself.	1	2	3	4	5
6. Displayed good communication skills.	1	2	3	4	5
7. Was alone and isolated.	5	4	3	2	1
8. Interacted well with other children.	1	2	3	4	5
9. Was interested in what was happening.	1	2	3	4	5
10. Lacked satisfaction with own performance.	5	4	3	2	1
11. Got on well with other children.	1	2	3	4	5
12. Needed constant reassurance.	5	4	3	2	1
13. Displayed leadership qualities.	1	2	3	4	5

TOTAL ____

÷13 = AVERAGE SCORE ____

Appendix 6

nferNelson
understanding potential

Revised Rutter Parent Scale for School-Age Children

Child's name: _____ Age: 9

Below are a series of descriptions of behaviour often shown by children. After each statement are three columns: *Does not apply*, *Applies somewhat* and *Certainly applies*. If your child definitely shows the behaviour described by the statement, place a cross in the box under column 3 *Certainly applies*. If your child shows the behaviour described by the statement but to a lesser degree or less often, place a cross in the box under column 2 *Applies somewhat*. If, as far as you are aware, your child does not show the behaviour, place a cross in the box under column 1 *Does not apply*.

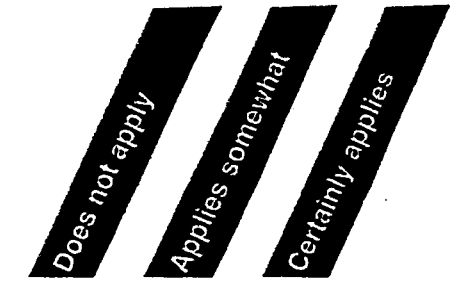
Please complete on the basis of your child's behaviour *during the past three months*.

Put *one* cross against *each* statement. Thank you.

This statement ...	Does not apply	Applies somewhat	Certainly applies
1. Tries to be fair in games			X
2. Very restless, has difficulty staying seated for long		X	
3. Considerate of other people's feelings			X
4. Squirmy, fidgety child		X	
5. Often destroys or damages own or others' property		X	
6. Has had tears on arrival at school or has refused to go into the building in the past 12 months		X	
7. Will try to help someone who has been hurt			X
8. Frequently fights or is extremely quarrelsome with other children		X	
9. Gives up easily		X	
10. Not much liked by other children		X	
11. Volunteers to help around the house or garden		X	
12. Often worried, worries about many things			X
13. Tends not to finish things started, short attention span		X	
14. Spontaneously affectionate to family members			X
15. Tends to be on own, rather solitary		X	

2

iis statement . . .



- Irritable, touchy, is quick to 'fly off the handle'
- Kind to younger children
- Often appears miserable, unhappy, tearful or distressed
- Resentful or aggressive when corrected
- Blames others for things
- Comforts a child who is crying or upset
- Has a stutter or stammer
- Has other speech difficulty
- Truants from school
- Has twitches, mannerisms, or tics of the face and body
- Frequently sucks thumb or finger
- Gets on well with other children
- Has stolen things on more than one occasion in the past 12 months
- Cries easily
- Frequently bites nails or fingers
- Is often disobedient
- Tries to stop quarrels or fights
- Has wet or soiled self this year
- Cannot settle to anything for more than a few moments
- Forceful, determined child

3

This statement . . .

	Does not apply	Applies somewhat	Certainly applies
36. Shares out treats with friends		X	
37. Tends to be fearful or afraid of new things or new situations			X
38. Kicks or bites other children	X		
39. Stares into space, stares blankly	X		
40. Plays imaginatively, enjoys 'pretend' games		X	
41. Fussy, or over-particular child	X		
42. Inattentive, easily distracted	X		
43. Independent, confident child		X	
44. Doesn't share toys	X		
45. Helps other children who are feeling ill			X
46. Often tells lies	X		
47. Bullies other children	X		
48. Kind to animals			X
49. Often complains of aches or pains			X
50. Inconsiderate of others	X		

Completed by: MRS Date of completion: 15/11/04.

Signed: Thank you for your help in this study.

Appendix .1

NFER-NELSON
INFORMING YOUR DECISIONS

BURNETT SELF SCALE (BSS)

Name ..... Child 2 ..... ID .....

I am ..... 9 ..... Years old. I am a ..... boy ..... (boy or girl).

I am in Year ..... 5 ..... The name of my school is .....

I have (how many) ..... 1 ..... brothers. I have ..... 1 ..... (how many) sisters.

I live with (cross one)

- [x] mum and dad.
- [ ] mum and step-dad.
- [ ] step-mum and dad.
- [ ] only mum.
- [ ] only dad.
- [ ] someone else (e.g. grandma).

Teachers name .....

Instructions: Here is a set of five statements which describe how children think and feel about themselves. Read each of the five statements carefully and then decide which statement best describes you.

Then put an X in the box next to that statement.

There are no right or wrong answers. Only you can tell what you really think and feel, so please mark the way you really think and feel and please answer *every* question. No-one else will be told what your answers are.

For example:

- [ ] I really like ice-cream.
- [x] I like ice-cream.
- [ ] I sometimes like ice-cream.
- [ ] I do not like ice-cream.
- [ ] I really do not like ice-cream.

This person likes ice-cream but does not love it. If the person really liked ice-cream she or he would have put a cross in the box next to the top statement. If the person really did not like ice-cream he or she would have put a cross in the box next to the bottom statement.

1. ☐ I really like the way I look.
   ☑ I like the way I look.
   ☐ I sometimes like the way I look.
   ☐ I do not like the way I look.
   ☐ I really do not like the way I look.

2. ☑ I really like sports and games.
   ☐ I like sports and games.
   ☐ I sometimes like sports and games.
   ☐ I do not like sports and games.
   ☐ I really do not like sports and games.

3. ☑ I really like spending time with other kids.
   ☐ I like spending time with other kids.
   ☐ I sometimes like spending time with other kids.
   ☐ I do not like spending time with other kids.
   ☐ I really do not like spending time with other kids.

4. ☐ I really like my mother.
   ☑ I like my mother.
   ☐ I sometimes like my mother.
   ☐ I do not like my mother.
   ☐ I really do not like my mother.

5. ☐ I really like my father.
   ☑ I like my father.
   ☐ I sometimes like my father.
   ☐ I do not like my father.
   ☐ I really do not like my father.

6. ☑ In general I really like myself.
   ☐ In general I like myself.
   ☐ In general I mostly like myself.
   ☐ In general I do not like myself.
   ☐ In general I really do not like myself.

7. ☑ I really like reading.
   ☐ I like reading.
   ☐ I sometimes like reading.
   ☐ I do not like reading.
   ☐ I really do not like reading.

8. ☐ I really like maths and sums.
   ☐ I like maths and sums.
   ☐ I sometimes like maths and sums.
   ☐ I do not like maths and sums.
   ☑ I really do not like maths and sums.

9. ☐ I really like learning new things.
   ☑ I like learning new things.
   ☐ I sometimes like learning new things.
   ☐ I do not like learning new things.
   ☐ I really do not like learning new things.

10. ☐ I feel really about myself.
    ☑ I feel good about myself.
    ☐ I sometimes feel good about myself.
    ☐ I do not feel good about myself.
    ☐ I really do not feel good about myself.

11. ☐ I am really good looking.
    ☑ I am good looking.
    ☐ I am OK looking.
    ☐ I am not good looking.
    ☐ I really am not good looking.

12. ☐ I am really good at sports and games.
    ☑ I am good at sports and games.
    ☐ I am OK at sports and games.
    ☐ I am not good at sports and games.
    ☐ I really am not good at sports and games.

13. ☐ I am really good at making friends.
☑ I am good at making friends.
☐ I am OK at making friends.
☐ I am not good at making friends.
☐ I really am not good at making friends.

14. ☐ I have a really good relationship with my mother.
☐ I have a good relationship with my mother.
☑ I have an OK relationship with my mother.
☐ I do not have a good relationship with my mother.
☐ I really do not have a good relationship with my mother.

15. ☐ I have a really good relationship with my father.
☑ I have a good relationship with my father.
☐ I have an OK relationship with my father.
☐ I do not have a good relationship with my father.
☐ I really do not have a good relationship with my father.

16. ☐ I feel really pleased with myself.
☐ I feel pleased with myself.
☑ I sometimes feel pleased with myself.
☐ I do not feel pleased with myself.
☐ I really do not feel pleased with myself.

17. ☑ I am really good at reading
☐ I am good at reading.
☐ I am OK at reading.
☐ I am not good at reading.
☐ I really am not good at reading.

18. ☐ I am really good at maths.
☑ I am good at maths.
☐ I am OK at maths.
☐ I am not good at maths.
☐ I really am not good at maths

19. ☐ I am really good at learning new things.
☐ I am good at learning new things.
☑ I am OK at learning new things.
☐ I am not good at learning new things.
☐ I really am not good at learning new things.

20. ☐ I feel really happy with myself.
☐ I feel happy with myself.
☑ I sometimes feel happy with myself.
☐ I do not feel happy with myself.
☐ I really do not feel happy with myself.

21. ☐ I really like looking at myself in the mirror.
☐ I like looking at myself in the mirror.
☐ I sometimes like looking at myself in the mirror.
☑ I do not like looking at myself in the mirror.
☐ I really do not like looking at myself in the mirror.

22. ☑ I really like running and playing.
☐ I like running and playing.
☐ I sometimes like running and playing.
☐ I do not like running and playing.
☐ I really do not like running and playing.

23. ☑ I really like playing with other kids.
☐ I like playing with other kids.
☐ I sometimes like playing with other kids.
☐ I do not like playing with other kids.
☐ I really do not like playing with other kids.

24.
- ☐ I really like being with my mother.
- ☑ I like being with my mother.
- ☐ I sometimes like being with my mother.
- ☐ I do not like being with my mother.
- ☐ I really do not like being with my mother.

25.
- ☐ I really like being with my father.
- ☑ I like being with my father.
- ☐ I sometimes like being with my father.
- ☐ I do not like being with my father.
- ☐ I really do not like being with my father.

26.
- ☐ I feel really proud of myself.
- ☑ I feel proud of myself.
- ☐ I sometimes feel proud of myself.
- ☐ I do not feel proud of myself.
- ☐ I really do not feel proud of myself.

27.
- ☑ I really enjoy reading.
- ☐ I enjoy reading.
- ☐ I sometimes enjoy reading.
- ☐ I do not enjoy reading.
- ☐ I really do not enjoy reading.

28.
- ☐ I really enjoy maths.
- ☐ I enjoy maths.
- ☐ I sometimes enjoy maths.
- ☐ I do not enjoy maths.
- ☑ I really do not enjoy maths.

29.
- ☐ I really enjoy learning new things.
- ☑ I enjoy learning new things.
- ☐ I sometimes enjoy learning new things.
- ☐ I do not enjoy learning new things.
- ☐ I really do not enjoy learning new things.

30.
- ☐ I really like being the way I am.
- ☐ I like being the way I am.
- ☑ I sometimes like being the way I am.
- ☐ I do not like being the way I am.
- ☐ I really do not like being the way I am.

31.
- ☐ I really have a pleasant looking face.
- ☑ I have a pleasant looking face.
- ☐ I have an OK looking face.
- ☐ I do not have a pleasant looking face.
- ☐ I really do not have a pleasant looking face.

32.
- ☑ I am really good at running.
- ☐ I am good at running.
- ☐ I am OK at running.
- ☐ I am not good at running.
- ☐ I really am not good at running.

33.
- ☐ I really have lots of friends.
- ☐ I have lots of friends.
- ☑ I have a few friends.
- ☐ I do not have many friends.
- ☐ I do not have any friends.

34.
- ☑ I really get on well with my mother.
- ☐ I get on well with my mother.
- ☐ I get on OK with my mother.
- ☐ I do not get on well with my mother.
- ☐ I really do not get on well with my mother.

35.
- ☑ I really get on well with my father.
- ☐ I get on well with my father.
- ☐ I get on OK with my father.
- ☐ I do not get on well with my father.
- ☐ I really do not get on well with my father.

36. ☐ I feel really confident in myself.
☐ I feel confident in myself.
☑ I sometimes feel confident in myself.
☐ I do not feel confident in myself.
☐ I really do not feel confident in myself.

37. ☐ I get really good marks in reading.
☐ I get good marks in reading.
☑ I get OK marks in reading.
☐ I do not get good marks in reading.
☐ I really do not get good marks in reading.

38. ☐ I get really good marks in maths.
☐ I get good marks in maths.
☑ I get OK marks in maths.
☐ I do not get good marks in maths.
☐ I really do not get good marks in maths.

39. ☐ I find learning new things really easy.
☐ I find learning new things easy.
☑ I sometimes find learning new things easy.
☐ I find learning new things hard.
☐ I find learning new things really hard.

40. ☐ I feel really satisfied with myself.
☐ I feel satisfied with myself.
☑ I sometimes feel satisfied with myself.
☐ I do not feel satisfied with myself.
☐ I really do not feel satisfied with myself.

Appendix 8 -: *Session Aims*

Session 1

- To introduce myself to the children
- To enable the children to introduce themselves to each other
- To explain the purpose of the proposed group work
- To seek agreement from the children for their participation in the research
- To establish ground rules
- To get to know each other
- To arrange the next session

Session 2

- To give the children an opportunity to ask any questions about the work
- To clarify that some of the sessions would be recorded using audio and video equipment
- To identify something that they would like to improve (the target)
- To enable each child to measure the current strength of their self belief concerning this (SFBT)
- To use imagery to develop the target (SFBT)
- To reinforce the desired quality (EMDR)
- To offer an opportunity for the children to discuss their experiences of the session

Session 3

- To obtain feedback from session 2
- To practise a technique from EMDR (the "butterfly hug")
- To check on self measurement of the target (SFBT)
- To reinforce the goal based on feedback (EMDR)

Session 4

- To obtain feedback from previous sessions and any between session change
- To check on self measurements (SFBT)
- To identify a positive experience from the past and to develop this (SFBT - exceptions to the problem)
- To strengthen the positive experience (EMDR)

Session 5

- To obtain feedback from previous sessions and any between session change. (SFBT)
- To discuss positive emotions in general and their effect (The psycho-educational aspect included in the EMDR process)
- To strengthen positive resources (EMDR)

Session 6

- To obtain feedback from previous sessions and any between session change (SFBT)
- To identify and measure the chosen positive cognition (EMDR)
- To identify and expand the preferred outcome (SFBT)
- To strengthen the preferred outcome (EMDR)
- Pulling it all together (EMDR)
- Explaining about the individual interviews and the subsequent final closure meeting

Appendix 9 -: *Reflections on the sessions*

My reflections on session 1

My initial reaction was of surprise that the children did not know each other. I was aware that they were all in different classes but I had expected that there would have been some awareness of each other. This may in fact indicate the level of isolation of these children within the school community. This made me even more sensitive to the possible difficulty that some of the children might have in communicating with myself and with each other. The drawings were helpful in providing a safe means for the children to express personal information about themselves. I suspect that if I had relied purely on verbal communication in this first session they would have found this more difficult. I realised that as I plan future sessions I will have to take account of the probable need to utilise 'scaffolding' of this nature to assist the process. Once the drawings were completed I invited each child in turn to tell the group about his or her drawing. This was helpful in two ways:

- I was able to use the information as I had planned as part of my assessment to add to the information each child had provided on the checklists.

- It was as a means of helping the group to begin to gel. In fact, a couple of the children spontaneously asked another child a question about his or her area of interest. In this way therefore, the drawings and my facilitation moved the process on quite quickly and established a positive base for future meetings.

My aim was to provide an individually tailored approach for each child within the setting of a group. The assessment phase of any therapeutic intervention, whether it be with an individual or within a group, is essential both for background information to draw upon when appropriate but also as a precautionary measure to guide the therapist in safe and appropriate therapy with that individual. This phase was particularly important with these children in view of the group context for the work. The areas of interest identified by each child provided me with information on the existing positive experiences that each child had. The purpose of this was to use these as a means of enhancing a positive belief later in the process.

The planning of the next and future sessions took account of the issues outlined above.

My reflections on session 2

The issue for me as facilitator of the group was how to structure and pace the activities to ensure that each child benefited from the techniques. Using open ended techniques drawn from SFBT, such as scaling questions and the miracle question, were helpful in this respect. The same instruction could be given to the group but the wording could be open enough to enable each child to work on an individual issue at their own pace.

The main issue to be kept in mind throughout my work was the necessity to carefully gauge the process to keep each child involved. The child who was slower to complete writing and who enjoyed the drawing tasks will require to be given enough time to

process information and not feel she is being stopped from completing her tasks. And yet, it is important that I move the process on in order that the more able boys will not lose interest and that each child will engage with the therapeutic work at each stage. This aspect of providing therapy within the group will be encompassed in the planning of each session. My skill and experience as a psychologist and therapist will be crucial in the judgements that I make moment by moment within the process of each session.

The sharing of experiences will be used both to provide me with feedback to check individual therapeutic safety and as a means of supporting the group dynamics.

My reflections on session 3

Only two children attended this session. I was uncertain whether or not to continue. The two children were very different. One presented in previous weeks as being thoughtful and quiet although he was articulate. The other child appeared to be slow at learning. I was unsure how or if they would interact with each other. My other concern was that if I continued the process with these two children what would happen the following week when the other children returned. Would it be difficult for me to hold the group together? As with any therapeutic decision when faced with a client the therapist must make decisions on what to do based on knowledge, information and sometimes gut feelings. The two children were in front of me expecting a session. I decided it would be unfair to send them away so with a deep breath I continued. I was pleasantly surprised at the end of the session to realise that I had made the right decision – both children appeared to gain something from the experience and I managed to facilitate some interaction between

them. My planning for the next session would need to take account of the children who missed that session. A flexible approach would be required to merge the five children again. I planned to incorporate this into the feedback discussion at the start of the session.

My reflections on session 4

By approaching the instructions in this way each child was able to work on his/her personal target. In this way the therapy was individualized within the group setting. My instructions for this activity mirrored to some extent the structure in the EMDR protocol. However, I did not ask the children to get an image of a negative target. Instead, I asked them to focus on a positive event. I was drawing on a previous positive experience (a positive resource) and using imagery and some techniques from Neuro-linguisic Programming (NLP) Grinder and Bandler (1979), O'Connor and Seymour (1990

The tricky part for me was to keep an eye on each of the children as they were all imagining a different scenario. Before moving into the imagery stage I checked with each child to make sure that they were going to target an appropriate area and that their image was safe. I did not want to interrupt the process too much once they had started as this could have lessened the effect. If I had started to ask them questions this would have taken them into a cognitive domain. I needed to keep them in the feeling domain and work towards being aware of any bodily feelings associated with their positive image. I was particularly aware of their facial expressions and gestures as a means of assessing their progress. This is something that I do when I work with an individual but in this group situation I was assessing five children's reactions at the same time. My uppermost

consideration at all times was the safety of each individual child. After the activity the feedback from each child was very positive. They shared their experiences within the group. Each child described a positive experience.

My reflections on session 5

This session was planned around empathy. Some children found it difficult to identify strengths in another child. But I decided to include this activity as I thought that it might be useful for future relationship building. I had to consider pace and speed of delivery to suit all of the children (one of the difficulties of working with a group). How did I do this? Again, I think it was about be alert and very aware of the reactions, spoken and unspoken, of each child during the sessions and as the process continued.

The strength cards seemed to work for most children. They seemed to relate to the animals. I think the fact that this was not about them or their relationship with others helped them to engage with the learning underlying the statement ascribed to the animals. I had chosen a selection of cards which in my view related to some aspect that I considered was relevant for a child or a number of children. It appeared to work as the children were drawn to a card which seemed to me to be pertinent to that child's life.

My reflections on session 6

I had mixed emotions today: pleased that the work had gone so well but a little bit sad that this was more or less the end of the group-work apart from the final feedback session to the children to round my work with them off. It was a good session. All of the children

were present. One child started to talk about his family issues. This was tricky for me as I did not want to cut him off as he had been quiet before and he was now spontaneously volunteering information, albeit of a personal nature. I decided to steer the conversation away from this topic to ensure confidentiality for him and his family. He also said that he had been bullied at school in the past. This boy had been quite reticent in early discussions. However, it seemed as if by the end of the group-work he had gained confidence and trust in the group. For me the dilemma was that it was positive that he felt more confident and able to express his feelings but at the same time I, as therapist, had a professional obligation to keep him and his family safe. When doing work like this with children it is essential to set ground rules (as I did) around issues of confidentiality. The therapist needs to be alert and sensitive to any confidential material that might be mentioned.

There were some indications that the work had made a difference, or at least that there was a perception on the part of the children that it had made a difference. The children were all able to identify something that had improved or that they had got better at since the start of the group-work, for example, swimming, basketball, maths and spelling. Also, one child's teacher had stopped me in the corridor to tell me that the child was now talking more in class.

Semi-structured interview

1a. Who asked you to take part in the group?

b. Was it your choice? (If not, whose choice was it?)

c. What did you think the group would be about?

d. How keen were you to be part of the group
On a scale of 1 to 10
(I didn't want to go 1----------10 I was really looking forward to the group)

2. Now you have been through the group meetings what would you tell another boy or girl who might be thinking of being part of a group like that? (How would you explain to them?)
(Prompt – Would you tell them to go to the group?
Why? /why not?)
(Tell me a little about what the group was about)

3a. What did you like about the group work?

b. Which parts did you find helpful?
(Prompt - Any thing else?)

4. What else do you remember?
(Prompt – Was there anything that surprised you? E.g. who was in it, what we did.
(Probe - What else do you remember?)

5a. Which things did you find easy in the sessions?

b. Which things did you find more difficult?
(You told me that you found --- difficult. On a scale of 1 to 10 where 1 is easy and 10 is very difficult -----)

6a. Tell me about something you learned from the group work?
(What else?)

b. Have you used any of the things you learned? (If not, why not?)

c. Tell me about this?

d. How does that help?

7a. If you had been on your own, instead of with the other children, how would that have been different?
(Would it have been better/not so good?)

b. What are the reasons for this?

8a. If there was a video camera taking a film of you in your classroom now, what might your teacher see in this film that was different from before you started coming to the group?

b. If there was a video of you at home, what would your family notice that was different?

c. Who else might notice something different?
(E.g. playground, out of school, etc.?)

d. What would they notice?

9a. What have you learned from the group work that will help you in the future?
(Prompt for behaviour, feelings, thoughts, beliefs, etc)

b. Which particular parts of the work made you think about this differently?

Do you remember anything else we did?
How helpful was that?
How much did you enjoy that?

Are there any things we did that you think worked well together?
Tell me about that

I: Interviewer
A: Alasdair

I: Feedback session EMDR solution focused brief therapy. Feedback with individual children fourth of March 2005.

I: Right. So what did you do at break time anyway?

A: Em I talked with my friend em because we've got em this computer game at home [I: Uh huh] em called long total war [I: Oh right] em and we were going to have a two player on it em when I'm going around to his house on Saturday [I: Uh huh]. So like em we were planning like which soldiers to have on this and things.

I: Oh right. Good. So you've got it all organised [A: Yeah] now. Good. Okay. That's great. Anyway, eh do you remember when we last met as a group [A: Yeah] I said to you all I'll come back and see you all individually [A: Mmm mmm. Yeah] on your own just so that you can tell me a bit about the group. Remember?

A: Yeah.

I: Em. So that's what we're doing today. I'm going to see everybody. Not all today. I've seen somebody [A: Mmm mmm] already and then I'll maybe come in next week to see other [A: Mmm mmm] people. Em and if you remember I said also that em we'd talk a little bit about what you liked and what you found [A: Mmm mmm] helpful those kind of things.

A: Yeah.

I: Yeah. I've put the tape recorder on [A: Mmm mmm] so that I don't have to write down everything [A: Mmm mmm] but I might write a couple of things just to jog my memory. Is that okay?

A: Mmm mmm. Yeah.

I: Good. Okay. So the first thing I 'd like to ask you is, who asked you to take part in the group?

A: Um.. I think em according to my mum. Eh phoned [I: Mmm mmm] em to get my mum and dad's permission for me to do it. [I: Right] Em.. and then I think I got a letter em at one point em.... I don't know what it was about because I gave it to my mum [I: Uh huh] and I think it had em in the end it had em details and things on.

I: Right. Okay. And was it your choice to come to the group?

A: Um.... I think I had the choice.

I: Yeah.

A: Um.. I think that's one of reason[phoned.

I: Right. Okay. To check that out [A: Yeah]. If it was okay. Okay. So before the group started, when you heard about it what did you think the group would be about?

A: Em... Or.. em, I heard what it was all em about like em. My mum said em sort of em to help a teacher [I: Mmm mmm] em sort of thing em and Mr said the people who were going would be good to em h..help and things and..

I: Right. Okay. Good. And remember we did a lot of scaling em from one to ten when [A: Yeah] we

were in the group. I'm going to do a scaling question now [A: Mmm mmm] and if this was the scale of how keen you were to be part of the group before it started. If one is I didn't want to go and ten was I was really looking forward to the group. Where, where would you have been before it started?

A: Em… Maybe five.

I: About a five. Okay. That's good. Okay. And now that you've been through the group meetings what would you tell another boy or girl who might be thinking of being part of a group like that?

A: Em… That it's okay really [I: Mmm mmm]. Em… Like nothing like, may like, em sort of s..sor em at class sort of em sort of math work and spelling and things like that.

I: Right. So it's, in..it wouldn't be like class work. [A: Yeah] Uh huh.

A: It's sort of the opposite.

I: Right.

A: Em.

I: How would you explain that? What do you mean by the opposite?

A: Well em… like… It's not like sitting down to like starting work [I: Uh huh] and all that sort of stuff. It's like just talking and things where you can't do it in class and things so.

I: Right. Okay. And would you tell the other boy or girl that to go to the group or not?

A: Em. Yeah. I think so.

I: Right. Okay. Tell me a little bit about what the group was about. What you remember about it.

A: Well, it definitely helped in swimming.

I: Oh yes. Uh huh.

A: Um….

I: Tell me a bit more about that though.

A: Well um… like um before like I absolutely hated swimming because like I was never confident in water [I: Uh huh] em and my mum and dad were surprised that em I wasn't that confident in water [I: Yeah] because like em my brother and my sister em.. both really really love swimming [I: Mmm mmm] em but like em swimming is like my least favourite activity and things.

I: Right. Okay. But you said that you think this helped [A: Em, yeah] being in the group?

A: It boosted my confidence a bit so.

I: Right. Okay. That's excellent then…. So which parts do you, do you think you found helpful then Alasdair?

A: Em well, the tapping..the shouldier, the soldiers oh I can pronounce it properly em..

I: Yeah, tapping the shoulders.

A: Yeah.

I: Uh huh.

A: Em.... Em sort of em walking round the room and things so.

I: Oh yes. Uh huh. Where we were kind of marching [A: Yeah] around the room weren't we. Yes. So what do you think was helpful about that for you?

A: Aw, em... It just helped on like em like things that I'm not too confident at and things [I: Mmm mmm] and... all that kind of thing so.

I: Right. And, and the tapping and the walking around the room helped [A: Yeah] too.

A: Yeah.

I: Do you feel more confident?

A: Mmm mmm.

I: Yeah. Good. Okay.... Anything else that you found helpful?

A: ... Em.... Not really. Em, like those were the main things that [I: Mmm mmm] helped. Em, but like sort of when we had to like imagine things [I: Oh yes] it helped but em not as much as the other two things.

I: Right. Okay. So the tapping and the walking around the room [A: Yeah] helped. And the imagining things helped a bit.

A: Yeah.

I: Yeah. Okay. What else do you remember?

A: Em.... Well I think at the beginning em we had some sort of sheet to fill in.

I: That's right. We did. [A: De..] Yes.

A: Details of us and things.

I: That's right. Yes.

A: Em.....

I: That was [A: Yeah] a way back at the beginning wasn't it.

A: Yeah.

I: Yes. I remember that. Uh huh. And anything else? [A: Em] What other things did we do that you remember?

A: We all had to like write things that what we thought of the other person.

I: Oh yes. Uh huh.

A: Em....

I: What was that like for you?

A: Em… Okay.

I: Uh huh.

A: Em. I couldn't really say it was the best but [I: No, no] it helped slightly so.

I: Right. Okay. Do you remember what you wrote then?

A: Em.. No I don't think so.

I: No [A: Uh huh] Who were you writing about can you?....

A( ) I think.

I: Right. Okay( ) was it?

A: Oh yeah.

I( ) That's right [A: Mmm mmm]. I think I remember that now in fact was it not something about his clothes, about his…

A: Oh yes. Style.

I: His style. That's right [A: Mmm mmm]. Yes. How do you think that made Stuart feel?

A: Em. No idea.

I: Right. Do you know what I think about that? I think( ) found that very helpful [A: Mmm mmm] because em that was like you giving him a compliment {A: Mmm mmm]. Do you know what I mean by compliment?

A: Yeah.

I: Yeah. I think he was really quite proud that you had thought that about him. That he had good style.

A: Mmm mmm.

I: Yeah so. It.. I think you were being helpful [A: Mmm mmm] to other people in that as well [A: Mmm]. Yeah. Do you think that is something that the group eh helped with? People helping each other.

A: Em, yeah.

I: Uh huh. In what way would you say /

A: Em, sort of thinking more of yourself [I: Uh huh] eh sort of sor.. em sort of ignoring like what you're like and things.

I: Right. Okay. And thinkir~ about somebody else [A: Mmm mmm] as well. Yeah. Okay. Was there anything that surprised you.

A: Em… Well when the cards came out [I: Uh huh] because I think that's probably the last.. least the last thing I would've expected so.

I: Oh right. Uh huh. So in what way did you find that surprising?

A: Em.. Well it's like sort of when you tend to find these things it's sort of like.. in infants building (inaudible) [I: Uh huh] sort of p one and p two.

I: Right. So you associated those kind of cards with the younger children.

A: Yeah.

I: Uh huh. And then you were surprised and you saw them. What did you think when we used them?

A: Em... Well I couldn't say it's a bad idea.

I: No.

A: Em.. But again em like it wasn't the best.

I: Okay.

A: ... so.

I: Okay. Which things did you find easy in the sessions.

A: Em... Just doing the imagining.

I: Mmm mmm.

A: I think that's about it really.

I: That's about the easiest. And which things did you find more difficult?

A: Aw em.... it like em at first the swimming like em I had tried like eh.. like we go to the hospital because we have family problems [I: Mmm mmm] at home [I: Mmm mmm]. So eh.... like, em I talked about swimming there [I: Uh huh] and.. but she couldn't really say em what would help [I: Right]. Em.. So em it sort of helped a bit with swimming.

I: Right. So doing this stuff in the group [A: Mmm mmm] was helpful with swimming even though [A: Yeah] you'd been to the hospital and talked about it.

A: Yeah.

I: Yeah. Okay. That's good to know. And thinking about all the activities that we did and all the stuff that we did each week [A: Mmm mmm]. Which of those things were more difficult did you think for you to do? When we were doing them.

A: Em..

I: Where there any that you found a bit more difficult? You said that the imagining was easy. Where any of the bits more difficult?

A: Em..... Not rea...

I: No.

A: Not really.

I: No. That's okay. That's fine… And you tell me something you learned from the group work? What would you say you learned from it all?

A: Em… like em… like you can be confident at things like if you work at it.

I: Uh huh. So you can be confident at things if you work at it.

A: Yeah.

I: Uh huh. Okay. And what else?

A: Em.. That like things aren't like em impossible to do sometimes so.

I: Uh huh. Things aren't?

A: Impossible.

I: Oh they aren't impo… Ah right. Ah. That..that's interesting isn't it.

A: Mmm mmm.

I: Uh huh. And how might that have changed you do you think?

A: Um…. Well I was never the most confident person in the world [I: Uh huh]. Em.. So it sort of boosted my confident a bit [I: Okay] sometimes so.

I: Good. Okay. So by learning some of these things that you can be confident at things if you work at them.

A: Yeah.

I: Helped you to boost your confidence [A: Mmm mmm] too.

A: Yeah.

I: Yeah. And what you said also was you learned that things aren't impossible.

A: Yeah.

I: Yeah. How do you think that will help?

A: Em… Well I know that I can do things [I: Right] like if.. like em I actually try so.

I: Yes. Good. Okay…. Have you used any of the things you've learned?

A: Yeah. Sort of in bed [I: Mmm mmm] and things.

I: Mmm mmm. Tell me a bit about that please.

A: Em… Well I sort of do the tapping [I: Yeah] and thing. And like I'd discovered that it also helps when you're scared as well [I: Oh right] because eh like I was believed in ghosts and things [I: Uh huh] so like em.. like when I get scared I keep like imagining things in front of my eyes [I: Mmm mmm] and like I sort of keep seeing sort of black figures like going through my bedroom door and things.

I: Right. Mmm mmm.

A: Em… And.. sort of like em.. like I'll won.. like I'll always wonder like em.. what's going to happen in the night.

I: Yes.

A: So.

I: So it was a bit scary [A: Yeah] when you imagine these things. Uh huh.

A: Mmm mmm. And I think it was just last night em when like my dad was in a rush because like he's a minister [I: Uh huh] and like he had, like em like he's really busy because like he works in four places. He works em in a church called St. [I: Mmm mmm] em down the road were country park is.

I: I know that yes.

A: Yeah [I: Yes] and..and a church up in [I: Mmm mmm] eh and then he works in another place in [I: Mmm mmm] em while they organise funerals [I: Right] and then he works at a school.. Em… And I think he em has to go on the radio as well [I: Right] so.

I: So he's quite busy.

A: Yeah.

I: Uh huh. And last night you were going to say?..

A: Eh. Like.. em my mum told me to drop off em some… eh… em like this folder with all my dad's working and things [I: Mmm mmm] and I didn't really realise em how dark it was sort of in the middle of our street [I: Right] because eh.. like em there's like a light post that needs repaired [I: Mmm mmm] em because a car crashed into it at one point [I: Yes] em like so it made it all dark and em I kept thinking that someone was following me al..all the way [I: Mmm mmm] because em when was murdered [I: Uh huh] like it was just up the road from me so like [I: Yeah.] em like em.. and when I heard about that em I wasn't terribly confident [I: Right] and [I: Of course] so ah.. Sort of that's sort of changed things a bit.

I: Right. Okay. Wh..what do you think.. How did it change things then for you?

A: Well, em… Like.. when like it gets dark like I don't like to like go outside [I: Mmm mmm] em because there's like some bits there with em like in gardens and things [I: Mmm mmm]. Em like it can be like pitch black at time [I: Right. Okay] and and like you can never see and then like… em like sometimes I see sort of white sort of [I: Mmm mmm] lines and things like [I: Ah] going across.

I: Right. Okay. And..and just going back to what you said sometimes em you used to imagine eh a figure or it was scary [A: Yeah]. So what..what is it you've done.. what have you used from what we've done [A: Em] in the group?

A: The tapping.

I: The tapping. Okay. And how do you do that can you tell me [A: Em] or show me?

A: Just like *thas*.

I: Right. Like a butterfly hug.

A: Yeah.

I: Yes. Yeah. How does that work do you think?

A: Em... Sort of.. it like acts.. like sort of.. em.. sort of someone like with me, beside me and things.

I: Right. Yes.

A: Em.. Like so like it.. makes like things less scary [I: Right] but it's like just when I eh sort of think that really there's no one there it sort of starts getting scary again and things [I: Right] so.

I: Okay. So it is scary but the tapping, butterfly tapping..

A: Yeah.

I: .. makes it less scary. Is that, is that what your saying?

A: Yeah.

I: Uh huh. Okay. And I think you talked about using that kind of tapping to help you with swimming as well [A: Yeah] didn't you. Yet. And, and was that to make you feel more confident too?

A: Yeah. Because like em like our swimming teacher like is like can be more strict than she needs to be [I: Right] because like em even like at.. ah parents who came with the class said that she's a dragon [I: Oh right (laughs)] so em.

I: Uh huh. Okay....

A: So like she can really be really strict and like em.. she like.. em always thinks of like the dangers like in the water [I: Uh huh] but she never thinks of the dangers of sort of getting in the water [I: Right. Okay] because eh.. she like.. the at Greenhall where we do it [I: Mmm mmm] eh like eh people there eh sort of went into the pool like the way like she told us to [I: Mmm mmm] but like, that it was like one of the most dangerous ways [I: Mmm mmm] like and she like ch.. em chipped her tooth [I: Oh dear] when she was going down [I: Mmm mmm] and like ev..every time we go em like some accident has happened going [I: Oh I see] in the water.

I: Right. Okay. So that's the time where people need to be careful.

A: Yeah.

I: Yeah. Okay. So let me ask you another question now. Em. I asked you about have you ever used some of the things you've learned.

A: Yeah.

I: And a bit about how that helps. Okay.

A: Yeah.

I: So what I'd like to ask you now is. If you had been on you own doing all this work that we did together instead of in a group with other children. How would that have been different do you think for you?

A: Like em... It's like easier like to say like what you want whether it's like in a group there's lots of people who need to em say and things so.

I: Uh huh. So in a group it's easier to say some of the things?

A: Yeah.

I: Yeah. Wh..what kind of things do you think wo..would be easier to say? What do you mean by that? Can you give me an examp....

A: Sort of like em.. like when other people say something [I: Uh huh] eh.. like.. em... If they're not confident on something you like em realise that you're not the only one who's not confident [I: Ah right] you see so.

I: Yes. So you realise you're not alone like [A: Yeah] that. Yeah. So, so that, is that helpful to you?

A: Em, yeah.

I: Good. Okay. So hearing about that from the other children was useful [A: Yeah] (inaudible) it sounds. Yeah. Any other reasons why it's better to do this work in a group do you think?

A: Em... Not really.

I: No. That's the main one is it?

A: Yeah.

I: Yeah. Okay. So the next thing I want to ask you. It's a bit of a strange questions really I'm going to say. If there was a video camera taking a film [A: Mmm mmm] of you in your classroom now [A: Mmm mmm]. What would your teacher see in this film that was different from before you started coming to the group?

A: Em... Well sort of em... I'm like sort of got my head down more often because like.. em... it's easier to be more confident in [I: Uh huh] em things.

I: Right [A: So]. So your teacher she looked at this film she would see your head down more often.

A: Yeah.

I: Uh huh. And what else would she notice that's different?

A: Em... Well... em that I'm not asking qu.. em questions as much.

I: Right. Okay. Uh huh. Is it [A: Yeah] your teacher? Okay. So would notice your head's down more [A: Yeah], you're doing your work more, you're not asking as many questions. What else might [illegible] notice on this film?

A: Em....

I: That's different from before you did the group.

A: I think that's just about it really.

I: Was there.. Are the main things. Okay.

A: Yeah.

I: And this time. If there was a video of you at home that [A: Mmm] was taken now. What would your family notice that was different do you think?

A: Aw.. Em.. I'm not terribly sure [I: Mmm mmm] because like at home.. like I tend to be okay

because like ah.. like I'm not, don't like have to do things that I'm not as confident at and things.

I: Right. Okay. So you don't have to do so many of the things that you don't feel confident about [A: No] at home. Uh huh. Do you think your family would notice any difference?

A: Em... No because sort of every time when I come home it's sort of the same routine sort of ah... I like sort of go home like and get a drink [I: Mmm mmm] and sort of um watch some telly and like heading up to like sort of tea time [I: Uh huh] em like... em I might be like outside before it gets dark [I: Right. Okay] or em sort of on the computer so.

I: Mmm mmm, mmm mmm. Okay. So at, at home you've got your mum, your dad and your brother was it?

A: Yeah [I: Uh huh]. And my younger sister.

I: And your younger sister. Okay. So.. em.. uh. I wonder who else might notice something different about you then apart from Miss ( ) Is there anybody else, anywhere who might notice something different?

A: Not really because like em... on like em... like... I like, I only really have one proper friend [I: Mmm mmm] like in the class and like eh... he's sort of always the fastest to get finished [I: Right. Okay] em like with all the correct answers and things [I: Uh huh]. Sort of he's always got his head down [I: Right] and like I'm usually like one of the last because like em like according to like teachers and *'hings* I'm just naturally slow at doing work and things so.

I: Okay. Okay. And what about other places you know? Let, lets say there was a video of you either in the playground or out playing somewhere or going to some activity or going swimming or whatever...

A: Well, eh... In the playground em sort of got worse em because like and there's someone called ( ) [I: Mmm mmm] eh.. like em.. and like he doesn't nip like em ( ) like my best friend [I: Mmm mmm] and like we've known each other since we were toddlers [I: Yes] em and they've not got many friends anyway, I don't know why because th.. like em I'm really, really am popular.

I: Right. Okay.

A: Em, so like he doesn't em let me stay with ( ) as much [I: Right]. So like in the end we just like have to deliberately like dodge ( ) and things [I: Right] because like. Em, and sometimes it's jus.. it's not em just me because like when someone else is talking eh like ( ) sort of em just comes in and sort of interrupts [I: Mmm mmm] em....

I: Which, which year is ( ) in?

A: Em, primary five like me. He's [I: Right] in the same class as me...

I: Same class. Okay. I'd like to ask you another question ( ) now. And we've talked a lot about what we did in the group [A: Mmm mmm] and you know what ( ) 've learned and what you liked and you've told me some of the things that you've learned but m..my next question is. What have you learned from the group work that will help you in the future?

A: Eh.... Well, em... Sort of, em..... like I can be confident at things [I: Uh huh] like so.. em I'm not going to be like as em.. this confident like in the future [I: Right]. Em..

I: You're not going to be as less confident. So y..you're going to be more confident do you think?

A: Yeah.

I: Yeah. Okay. In the future. Uh huh.

A: Em.... Like em I don't really have to worry em about.. em sort of.. em.. Being confident at.. at sort of doing my work like getting wrong answers and things like that.

I: Right. You don't have to worry as much about that. Yeah. Okay. Good. Okay. Which parts of the work that we did in the group do you think made you feel differently or think differently about these things? Which bits that we did because we did a lot didn't we.

A: Em... Well, em... Like you mean sort of like um tapping your should... em sorry se em soldiers em and em sort of going around the room and things.

I: Right. Tapping your shoulders and do yo.. wh..when tapping your shoulders remember we did two things. We did in a line tapping the shoulders of the person in front [A: Yeah] and someone tapped yours and we also did that tapping [A: Yeah], the butterfly tapping. Which do you mean when you say to me you found the tapping the shoulders?

A: Em.. When you do it to yourself (inaudible).

I: Right. When you do it kind acro..across. The butterfly [A: Yeah] tapping. Okay. And going th.. around the room you found that helped [A: Yeah] you to think differently [A: Mmm mmm] about things. Good. Okay. That..that's very very helpful em(. ..) Wh..what I'd like to do I've got a, a little sheet here [A: Mmm mmm] em that I'd like you just to tick some boxes and [A: Mmm] I'll go through it with you and just explain [A: Mmm mmm] first of all what it is. And down here do you see those are all the activities that we did or most of them [A: Mmm mmm] that I could remember anyway and I've, I've listed them there and then you'll see here it says.. em, look at the list of activities we did in the group and please tick one box for each to say how helpful it was for you [A: Mmm mmm] and you can choose either not helpful, a little helpful [A: Mmm mmm], helpful or very helpful. Yeah [A: Right. Yeah]. So if you don't mind if you would fill that in for me [A: Right. Oh] Thank you.

A: (Filling in form) Ah, sorry.

I: It's alright. Do you want to use that rubber.

A: Mmm. Yeah.

I: Okay. [A: (Using rubber)] That's fine I'll know which one you mean.

A: Mmm mmm. (Filling in form)

I: Okay. And if you'd just put your name [A: Mmm mmm] there please so I know which is yours. [A: (Filling out name)] That's great. Thank you. And one more to do it's exactly the same activities down there but this time this one is asking you, please tick one box for each to say how much you liked it. So [A: Mmm mmm] first one it could be did not like it, liked it a little, liked it, liked this very much. Okay [A: Mmm mmm]. So if you'd do the same with that one please.

A: (Filling in form)

I: Thank you. And if you'd just put your name on that [A: Mmm mmm] one too please. Thanks. [A: (Filling in name)] Right. Thank you. And what I've done is I've written down as many of the activities that I could remember [A: Mmm mmm]. Is there anything you remember that I've missed out that you can think of that [A: Em] we did in the groups?

A: Don't think so.

I: You think I've got them all.

A: Yeah.

I: Yeah. Are there any bits that you think well those two things worked well together?

A: Em. Mmm. No. Not really.

I: No. They were all fine on their own.

A: Yeah.

I: Yeah. Okay. That's excellent. Well thank you very much for doing that [A: Mmm mmm]. Remember at the beginning I said to everybody, em, one of the reasons I was doing this group as well as to help people to feel better [A: Mmm mmm] and more confident was also to learn from you what you liked about the activities [A: Mmm mmm] and what were good [A: Mmm] so that I could think about that when I do other groups.

A: Yeah.

I: So thank you very much for being part of it. That's been really helpful for me [A: Mmm mmm] and I hope some of it's been a bit helpful for you

A: Yeah.

I: Yeah. Is there anything you'd like to tell me or ask that we haven't mentioned?

A: Em. Mmm. Not really.

I: No. Okay. What I thought we'll do, after Easter we'll maybe meet [A: Mmm mmm] as a group once more just [A: Mmm mmm] to pull it all together and just [A: Mmm mmm] say goodbye to [A: Yeah] everybody. Is that alright?

A: Yeah.

I: Yeah. Okay. So you'll soon be having your Easter holidays won't you?

A: Yeah.

I: In a couple of weeks.

A: Mmm mmm.

I: Good. Okay. Well thanks very much ( ) for helping me out here today and I think if you go back now you.. I understand from Miss ( ) it's golden time.

A: Yeah.

I: Is that right? [A: Mmm mmm] Okay. Thank you( )

A: Mmm mmm.

I: Right see you. Have a good holiday.

A: Thanks. Bye.

Appendix 12 4/3/05

Name _____

Here is a list of some of the activities we did at the group. Please tick one box for each to say how much you **liked** it.

	Did not like	Liked a little	Liked	Liked this very much
Drawing	☐	☐	☑	☐
Talking about things Listening to other children	☐	☐	☑	☐
Scales (on a scale of 1 to 10)	☐	☐	☐	☑
Butterfly hug	☐	☐	☐	☑
Visualising (Getting a picture in your mind)	☐	☐	☐	☑
Being tapped on your shoulders	☐	☑	☐	☐
Marching round the table	☐	☐	☑	☐
If a Miracle happened when you were sleeping	☐	☐	☐	☑
Talking at the beginning of each meeting about the past week	☐	☐	☐	☑
The discussion at the end of each meeting	☐	☐	☑	☐
Writing	☐	☑	☐	☐
Tapping your hands on the table	☐	☐	☐	☑
Remembering a time from the past when you did well	☐	☐	☐	☑
Imagining yourself in the future doing well	☐	☐	☐	☑
The strength cards	☐	☐	☑	☐
Saying positive words to myself	☐	☐	☐	☑

Appendix 12a 4/3/05

Name. _____

Here is a list of some of the activities we did at the group. Please tick one box for each to say how **helpful** it was for you.

	Not helpful	A little helpful	Helpful	Very helpful
Drawing	☐	☑	☐	☐
Talking about things Listening to other children	☐	☐	☑	☐
Scales (on a scale of 1 to 10)	☐	☑	☐	☐
Butterfly hug	☐	☐	☐	☑
Visualising (Getting a picture in your mind)	☐	☐	☑	☐
Being tapped on your shoulders	☐	☐	☑	☐
Marching round the table	☐	☐	☐	☑
If a Miracle happened when you were sleeping	☐	☑	☐	☐
Talking at the beginning of each meeting about the past week	☐	☑	☐	☐
The discussion at the end of each meeting	☑	☐	☐	☐
Writing	☐	☐	☑	☐
Tapping your hands on the table	☑	☐	☐	☐
Remembering a time from the past when you did well	☐	☐	☑	☐
Imagining yourself in the future doing well	☐	☐	☑	☐
The strength cards	☐	☑	☐	☐
Saying positive words to myself	☐	☑	☐	☐

Child 2 — interview with class teacher — 6/5/05

13

Confidence was a prob. - been
He knows he is able

Whole class has gelled.
I think I can do it but I'm not sure.
He volunteered.
became more confident
Given lots more of the beg & to express explain how he is feely.
- said why he's been unhappy.
It being OK to say but unsure.
* when less confident & insecure.
Sara copy tasks with others
& see self more indiv.
Mediator.

brother dominant ?/S2. - diff cars - fol.

Notts - wasn't get work finished prev. - so ⇒ couldn't do well
Slaves - more methodically. *
⇒ tedious

fascinated by history.

still asks for reassurance
is it ok.
prev sat in seat. T more (*)
proactive.

goes right direction.

Appendix 14

Post

nferNelson
understanding potential

Self-Esteem Indicator: Primary

Pupil's name: .... Class: P5a Age: .....

Administrator's name: . ..... Date: 6/5/05

Please answer all the questions. Circle the number to the right that you believe most accurately describes the pupil's situation/response to each question.

	Most of the time	Quite often	Occasionally	Almost never
1. If this pupil is encouraged, does s/he respond positively?	(3)	2	1	0
2. Is this pupil co-operative if something needs to be done or achieved?	(3)	2	1	0
3. Does this pupil usually enjoy and get on well with his/her work?	(3)	2	1	0
4. Does this pupil seem to be aware of what s/he is feeling (e.g. will this pupil tell you or show it if it is a strong feeling like excitement, anger or fear)?	3	(2)	1	0
5. Apart from you, does this pupil have significant adults who support and encourage him/her?	3	(2)	1	0
6. Does this pupil react reasonably if his/her school work is constructively criticised?	3	(2)	1	0
7. Do you feel interested/excited when you think of this pupil, rather than worried or annoyed?	3	(2)	1	0
8. Do other pupils like him/her?	(3)	2	1	0
9. Does this pupil enjoy having an opportunity to choose the activity s/he wants to do?	3	(2)	1	0
10. Can this pupil name some preferences and likes (e.g. food, friends, holidays, games, etc.)?	(3)	2	1	0
11. Has this pupil always got plenty to say to other people?	3	(2)	1	0
12. Does this pupil make a plan before attempting a task?	3	(2)	1	0
13. Can this pupil name his/her feelings (e.g. if you asked what s/he was feeling at some point in the day)?	3	(2)	1	0
14. Does this pupil like to play games with other pupils (e.g. games in pairs, sports teams, class quizzes, etc.)?	(3)	2	1	0
15. Does this pupil try something first before asking for help?	3	(2)	1	0
16. Can this pupil control his/her frustration and impatience?	3	(2)	1	0
17. Do other pupils often choose him/her to play with them?	3	(2)	1	0
18. Can this pupil read well for his/her age?	3	(2)	1	0
19. Does this pupil usually seem to be happy about things?	3	(2)	1	0
20. Does this pupil have any of the following – a best friend, a few close friends, a wide circle of friends?	(3)	2	1	0
21. Is this pupil independent, and does s/he like to do things his/her own way?	3	(2)	1	0
22. Is this pupil usually contented about things?	3	(2)	1	0
23. Does this pupil seem to get on well with you and other significant adults?	(3)	2	1	0
24. Does this pupil do sums well?	3	(2)	1	0
25. Does this pupil usually appear interested and curious about things?	(3)	2	1	0
26. Do you like this pupil?	(3)	2	1	0
27. Does this pupil like to look nice? (e.g. Have you seen this pupil tidying self up, or telling you about new clothes s/he has acquired, asking you to admire them?)	3	2	(1)	0
28. Is this pupil generally healthy?	3	(2)	1	0
29. Does this pupil initiate social activities relatively easily?	3	(2)	1	0
30. Can this pupil stand up for him/herself assertively rather than aggressively?	3	(2)	1	0
31. Does this pupil like to imagine being famous, powerful or extraordinary in some way (e.g. think of essays or roleplays s/he has done)?	3	(2)	1	0
32. Does this pupil spontaneously bring in objects, ideas or stories from home to share with the class?	3	2	(1)	0
33. Is this pupil reasonably competent at something s/he enjoys?	3	(2)	1	0
34. Does this pupil seem to like being a boy/girl (e.g. gets on well with the same sex friends and joins in with the more stereotypical masculine or feminine games fairly comfortably)?	(3)	2	1	0
35. Does this pupil comfortably make social overtures to a new pupil?	3	2	(1)	0
36. Does this pupil come over to you as being sure of her/himself?	3	2	(1)	0

Published by nferNelson Publishing Company Ltd, The Chiswick Centre, 414 Chiswick High Road, London W4 5TF, UK.

Overall self-esteem score	
Sense of self component score	
Sense of belonging component score	

Appendix 15

BEHAVIOURAL INDICATORS OF SELF-ESTEEM (BIOS)

post

RATING AND SCORING SHEET

NFER-NELSON

Student's Name ... . Date 6/5/05

Teacher .... Class P5a

Directions: Please circle the response that best describes the frequency of this student's behaviour over the past two weeks in the school setting. Sum the responses and divide by 13 to obtain an average score.

	Never	Seldom	Sometimes	Often	Always
1. Was confident in what he/she did.	1	2	3	**4**	5
2. Was withdrawn from others.	5	**4**	3	2	1
3. Appeared proud of him/herself.	1	2	**3**	4	5
4. Gave limited responses.	**5**	4	3	2	1
5. Appeared happy with him/herself.	1	2	3	**4**	5
6. Displayed good communication skills.	1	2	3	**4**	5
7. Was alone and isolated.	**5**	4	3	2	1
8. Interacted well with other children.	1	2	3	**4**	5
9. Was interested in what was happening.	1	2	3	**4**	5
10. Lacked satisfaction with own performance.	5	**4**	3	2	1
11. Got on well with other children.	1	2	3	**4**	5
12. Needed constant reassurance.	5	**4**	3	2	1
13. Displayed leadership qualities.	1	**2**	3	4	5

TOTAL ☐

÷13 = AVERAGE SCORE ☐

27/06/05. Interviewed Parents — — — — — ii 2

More voluble - articulating himself more
eg I feel "tense" .. whereas previously he seemed
He was unhappy inside.

Teacher told mother - A had asked if he could go out
to sort something out with his friend.
(he had been upset that his friend wanted to do something & he
wanted something else).
Teacher said yes - did he want her to help him to talk
to his friend about it. A said no he could do it on
his own. — went out with friend for about 5 minutes
— came back to class & they had sorted it out

Home - Previously was really left out.
Now a couple of friends come round to meet him

Dad - He is more confident (eg I said something & he
"pulled my leg" — mimicked me - quite a performance
he took dad (drama) — I laughed & said are you
'pulling my leg' — A 'yes')

Mum - ~~Dad~~ lot of positive things happened recently eg
eg did the log jump
took part in judo

Asked about concerns on initial questions
re after lunches - - -
Now - not as much worry - as he is having more positive experiences
re tortoise (blinks/screwing eyes up)
A Now hasn't had any in the last few months
(except of new sister.
Now improved - eg judo at school - then said wanted to go to club - this
Level of confidence has changed immensely (wouldn't have wanted this
now & talked about going with friend

27/6/05

Parents Interview notes

More voluble - articulate herself more

eg "tense"

formed pics

less unhappy inside

asked to can I go out & ask to stay to A to scout that was feely left out - now couple friends come to meet him performance type way eg pulled dad's leg..

ie more confident.

Dad long jump for school.

12 - often carried → not as much worry - as more pos experiences

tackles - not in last months.

49 aches & pains - not sure time.

~~37. I don't get up because I don't want to go to sch (now - I stay in bed as long as poss).~~

37. new sitting - improved - judo - wanted to go to club. In day-to - that level of confidence has changed immensely..

Dad - "This little prog has help him quite a lot"

Appendix 17

Appendix 17: Quotation exemplars

Master theme 1: The Therapeutic Journey

Child 1

Negative Cognition: I am alone and different ..... Positive Cognition: I can be myself

Interviewer (I) .. Okay. So if there was a video camera in your classroom making a film of you now what might Miss – (teacher) see in the film that was different from before you started coming to the group?

Well, em. Having a laugh with Miss - and em talking to her about ss things.

I: And what else might she see?

That I've em... got more confident with my work and em.. that em..... and I've started to em talk to people that I wouldn't really talk to in class cos em.... I thought I wouldn't really like them cos I've been swapped into different class cos all the classes got em shuffled about and I got people from different classes in my class. So like I've made friends with new people and [I: Ah right] she would've saw that I've em made quite a lot of new friends.
And that em I've made.. I'm like.. I've got em... Well I've made more friends on my street which I haven't known before like when they're just outside go up to them and em get them they would see that I think. Cos my new friends have been in my house too - and ... like.. and she (my Nana) would notice a big difference too ...she would notice that I've em made friends with the next door neighbour's children.

I was a wee bit nervous about coming to this group .. but then em when I met the people and started to know them like I've made more friends from them.

I: ..... And what do you do now then that shows you that you've made friends with them?

Well em... R (child 5) and.. R's just like somebody before the group I would just like say hi to when I was passing but sometimes I'll play games with R and D (boy who was not in the group).

And em.. sometimes S (child 3) comes to our, our classroom for em... for drawing at golden time and then like I talk to him then too and in the playground sometimes cos I see A (child 4) alone I'll feel sorry for her and ask her if she wants to come and play.

I: So, so you're being a friend as well as you've got more friends. Right. That's very good.. How does that make you feel now then?

Well, it just makes me feel em happy .. that I've got quite a lot of friends and em I can be a friend and be more confident.

I: ....tell me about something else you learned from the group work?

Em, well... To stay confident and em... like just be yourself.

Child 2

Negative Cognition: I am not safe.....Positive Cognition: I can become confident and be in control

like in the water .. but she never thinks of the dangers of sort of getting in the water..because eh.. she like.. the at the (swimming pool) where we do it..eh like eh people there eh sort of Well um... like um before like I absolutely hated swimming because like I was never confident in water .. em and my mum and dad were surprised that em I wasn't that confident in water .. because like em my brother and my sister em.. both really really love swimming .. em but like em swimming is like my least favourite activity and things.

Aw em.... it like em at first the swimming like em I had tried like eh.. like we go to the hospital because —. So eh.... like, em I talked about swimming there and.. but she couldn't really say em what would help. Em.. So em it (the group work) sort of helped a bit with swimming because, like em, like our swimming teacher like is like can be more strict than she needs to be .. because like em even like at.. ah parents who came with the class said that she's a dragon so em (...so like she can really be really strict and like em.. she like.. em always thinks of like the dangers went into the pool like the way like she told us to .. but like, that it was like one of the most dangerous ways .. like and she like ch.. em chipped her tooth ... when she was going down ... and like ev..every time we go em like some accident has happened going .. in the water.

Well I sort of do the tapping .. and thing. And like I'd discovered that it also helps when you're scared as well .. because eh like I was believed in ghosts and things .. so like em.. like when I get scared I keep like imagining things in front of my eyes .. and like I sort of keep seeing sort of black figures like going through my bedroom door and things.

Em... And.. sort of like em.. like I'll won.. like I'll always wonder like em.. what's going to happen in the night.

Eh. Like.. em my mum told me to drop off em some... eh... em like this folder with all my dad's working and things .. and I didn't really realise

em how dark it was sort of in the middle of our street.. because eh.. like em there's like a light post that needs repaired.. em because a car crashed into it at one point.. em like so it made it all dark and em I kept thinking that someone was following me al..all the way...

Child 3

Negative Cognition: I am no good ..... Positive Cognition: I believe in myself

I: Which particular parts of the work made you think about this differently do you think?

Em... Probably the bit where we were up around the room and every'hing.

I: Where we were walk...

Like eh runnin' around the room.

I: ... How do you think that made you feel differently? What was different there...

Cos you didn't like you had each other, you're tapping each other shooders an' then you didnay like yeh, yeh didnay have to say any'hing you just had to 'hink aboot what you had done, wha, what you could do an' every'hing so.

I: ..... Tell me something that you learned from the group-work?

To believe in yourself.

I: Uh huh. To believe in yourself. Okay. And what does that mean to you? What does it mean to believe in yourself?

Eh, like.. to... like not to doubt yourself like to say that you can day some'hing an' then try.

I: Uh huh. Yeah. Okay. In which particular bits do you think helped you with that?

Mmm. It was the...the...the cards with animals on it sayin'.

I: ...How did that help then?

It's just sayin' that eh some animals are good at other 'hings but some arnay so good so. So I just says thought I was like I was good at like my spellin' and every'hing but I'm not that good at maths.

I: Okay. It's quite a lot you learned though - to believe in yourself.

I: ....And now you've been to all the group meetings what would you tell another boy or girl who was thinking about being part of a group like that? What would you say to them?

Em. Just to go cos it can help yeh a lot mare with like your maths or whatever you're bad at.
Eh. Just gettin' help wey every'hing else [I: Uh huh] like my work and that.

I: Uh huh. Yeah. Okay. Mmm. What was that about? Explain a wee bit more to me what you mean by that?

Well. When I first came I wasnay that good at Maths even if my ma

maths... and then when I started goin' I can do my maths in like at least

about twenty minutes now but if it's like two pages ...

I: Okay. So here, so here is a funnier one now for you. Let's say there was a video camera in your classroom and it took a film of you in your classroom now. What might your teacher see in this film that was different from before you started coming to the group?

Eh, well I would nay be talkin' as much...

I: Right.

Cos I.. I used to just if I was stuck I would just leave and talk, talk all the time so.

I: Ah right. Okay. And what would Mrs ... see that's different now?

Em. I'll just have my heed down an' if I was stuck, if I was stuck I'd just ask someday an' I'd just work again.

I: It would be Mrs .... that would notice things that are different. Okay. What have you learned from the, the group work that will help you in the future?

Eh. Not to get down on yourself an' just to try wha' yeh want to dae so.

Child 4

Negative Cognition: I'm stupid .....Positive Cognition: I can achieve

..... I never done my homework but now I'm catching up.

And I'm really, really confident.

I: ... What else was helpful? You've told me a bit about that already..... (At this point she was so keen to tell me of her successes that she didn't wait for me to finish).

That, that, that I'm catching up with my times table ..because I'm up learning a lit'le of the times table I don't really know.
Well but... when I learned after the group finished that I'm learning a lit'le more about things than I didn't before.

I: Right. Okay. Can you tell me a bit more about that then?

Cos the last time I was here I didn't know much of my, of my spelling an' m.maths and I didn't even know my ten times table much but I got help finding out and it's just like.. the when.. at the begin of one to ten that you add a zero at it.

I: .... Uh huh. So after you've, you've been through all the groups and it's all finished now and in your back in your classroom and you're doing all your work everyday ... If there was a film made of that what would be different on that film

with that was different from a film before you met me and came along here?... What.. what might you be doing differently?

I might** [I: Now] **be doing.. other things that people wi..would be doing.

Like..... Like probably.. being... Like probably learning new things.

I: Yeah. Anything else Mrs ... would notice that's different?

That once that, once I never (inaudible) ***done my homework but now I'm doing it.***

I: So she'd notice that that's different [***Yeah****]. .. Anything else? What else?*

.. (sighs) ***If she, if she probably realise that I'm learning more than I used to like day dreaming .. and, and now I'm not day dreaming I'm just concentratin'. She'll probably be happier.***

I: Uh huh. Okay. And what about in the playground? What might be different in the playground now for you?

Like I used to play tig and hide and seek but now I'm not I'm just walking about.

I: Uh huh. Yeah. Okay. And what's different about that?

Cos if I run about I.. because I have a problem with my lungs cos I've got the asthma. So I have to walk instead of running.

Cos you .. Cos used to when I (inaudible) ***I just thought mum do I have to have*** (inaudible) ***I just want teh watch TV. ...***
But then I thought no TV till I've done the room.
Even though if I left my favourite programme I'll watch it another day.

I: Yeah. Anything else your mum would notice that's different?

She'll notice that, she'll no'ice that used to I just kep..kept my room in a state and .. now, now my room's perfectly clean an' I kept hoovering it up and pop.. and looking after my equipment even bet'er. And earnin' pocket money.

Child 5

Negative Cognition: I am not likeable..... Positive Cognition: I belong

.. an' sometimes at night ah have lack eh sleep.

Wonderin' what's gonna happen to me .. tomorrow .. em.. on... like a year ago ah was gettin' bullied so much ah... ah was ill then ah couldn't.. Ah didn't go back to school.. just in case. Cos half.. cos people were takin' my pencils and claimin' ma, my rubbers .. an' ah hardly not got anybody to play with.

I: .. So is this different from before do you think?

Yeah.

Now I've got tons of.. got lo.. tons of friends, about ten of them, ten or eleven.

Girls, girls and boys.

..... Ah had a big.... There was a party last night.

I: .. So you had a busy night last night.

Yeah. And this and also to meet other people you don't know.

Like I met (child 1) for the first time.

And we're friends.

Well before I, I usually stick around the playground .. just playin' with like my sister or.. just sittin' around talkin' to the wee ones *[I: Okay].* ***Like I've a cousin there. So...***

I: And now, if there was a film? What..

Well, ah would probably.. runnin' from R.. or... E... E.. is kind of bit fast. And yesterday we were playing tig. Ah.. ah was wearin' ma trainers what av go' on just now .. an'.. Em.. R's kind of bit fast. Taller than me. An' he nearly caught me but ah, ah just go' past him. And L... an' J.. were talkin' so ah started to walk an' ah shouted sucker .. an' ah started to run .. o' course R 2 was starting to catch me so ah better, ah run so fast.

I: .....Would anybody else notice anything different about you do you think now?

Yeah.

I: Who else?

My mum and dad and my auntie.

I: Right.

An' ma friends definitely. Ma friends [I: Right] they've been, just they see me actin' a bit strange lately .. now. And they fe.. an' they go on ahead with that an' am talkin' more to the popular people than the rest. And am... am been talkin' to like Edin.. We had a argument... over somethin'. So we're talkin' to each other. N.. is talkin' to me. R..is talkin' to me now. L's talkin' to me .. and yesterday something really weird happened. Someone, they were ask..in two boys were askin' me out.

I: So your friends would notice things have changed?.. And you said also your mum and your dad would notice? What might they notice that's different?

Well usually ah..I just stay in ma room. But nn comin' in, am com..in' into the living-room more now.

And am goin', am goin' eh ma Auntie's more.

I: .. So my next question is a bit about that then eh..... If there was a video camera taking a film of you in your classroom now [R: Oh no (laughs)]. What might your teacher see in this film that was different from before you started coming to the group?

Well..Well... Before we were goin' a'd be quiet an' get on with my work and .. don't bother, don't bother even in conversations and .. and the table .. and sometimes, sometimes ah, ah wouldn't even speak at all [I: Uh huh] and if they had a video camera just noo a'd be talking to ma friends.

I ... Anything else or anybody else that would notice things were different?

The teacher definitely.

I: .. And what would she notice?

She'll see higher standards .. of my work .. and my maths cos I'm really good at ma maths. And.. Ma spellin' is comin' on. Am gettin' everything right on ma spellin' test. .. And.... Am probably about... in.. and the, the smile on ma face at points. The teacher know ah have a smile on ma face ah had a good time or something.
An' the (spelling) ***words are kind of bit easy but I'll forget them about.. three or six months.***

Cos am, cos am dyslexic ah can't remem.. ah can't even say stuff like pineapple or that.
An' am gettin' all my answers right an' ma shapes an' a got.. an' a passed ma, ma level.. B so ah got to a level C (5 to 14 levels of attainment).

Cos before ah was kind, ah didn't really like school that much .. so... I.. ah didn't have ma.. Ah didn't pass ma levels.

An'.. An' ah didn't study that, as much so ah went to em... learning support.

I: .. So what's changed do you think ....?

Well. Av improved ma ma..maths quite a lot now.

And ah don't go eh learning support any more.

But the boy next teh me has t.. just noo but... He thinks am kind of bit brainy at ma maths.

So he's.. ah.. he, he always says do you know the answer to this so. So ah dunny give him the answer I just explain the question to him.

So he can get the answer.

Am more like his tu'or .. at,at school.....

Master theme 2: Therapeutic Techniques

Subordinate theme: EMDR techniques

I: .. Have you used any of the things that you learned from the group?

Child 1

Yeah. I've used the tapping.

I: .. Tell me a bit about that then, please.

Well em... When I do the tapping on my sh..should..shoulders I em I say the words like you can do it and em cos I used you can do it when I was learning my lines (for a school play) ***and like stuff like I can change [I: Uh huh] and em also tapping is.. on sh..shoulders can like em make me feel more relaxed and like sometimes when I can't go to sleep I use the tapping too.***

Child 2

Em well, the tapping the shoulder

Em.... Em sort of em walking round the room and things so.

Aw, em... It just helped on like em like things that I'm not too confident at and things .. and... all that kind of thing so.

Child 4

I: And what else?

I think it was about walking around in circle saying that ' you can do it'.

Child 4

I liked it when we, when we went around in a circle tapping each others' shoulder.

I: .. What was good about that?

Because it made me laugh a lot.

Child 3

I: ... ... Which parts then did you find helpful?

Tapping (on the table) ***and closing your eyes and sayin' 'I could do it.***

Child 5

I: Yeah. Okay. Anything else you found helpful then from the group work that we did?

The pattin' on the shoulder was definitely .. helpful. Because ah had a test coming up .. and ah passed it.

Instead of pattin' on the shoulder ah just pat around my waist just in [I: Ah right] because the t..table's below the below ma waist so *[I: Uh huh]* ***nobody can see what ah was doin'.***

Subordinate theme: SFBT techniques

Child 5

..... and ev.. the wee purple, the pink book you gave us av, I write some down and.. put a scale eh one to ten .. sometimes have five, sometimes have nine, sometimes have one.

I: .. So you used your little book for that?

Yeah.

I: Uh huh. And what kind of things do you write in it?

Well ah write about the day, what happened. It's more like a diary eh me. .. An' av, ah never knew it an' ah was finished an' ah had to start on a new book.

I: ... And you use scaling in it. Mmm mmm [***Yeah****]. How does that work then? How do you do that...?*

Well, um... Instead of puttin' a big long line of one to ten, .. I put different stuff like hearts, stars .. kind of bit of make like... make up accessories, cosmet *[I: Uh huh]...* ***and jewellery like that.***

I: Right. Okay. And what kind of things might you'd scale what might you do it on?

Em.. Ah.. Sometimes ma like ma nerves .. ma happ.. When am happy, sad .. excited.

I: .. And tell me a wee bit more about that. Is that helpful do you think or not helpful to you?

Helpful.

I: Yeah. In what way...?

So ah can, ah can record what I've been doin' since.. an' remember what ah did before an' ah can do it again .. to make me more happy.

Or if it was sad a'd try, I'd try an' do the opposite of it.

Subordinate theme: Combination of techniques

Child 1

I: ... Are there any things that we did that you think worked together? You know, they worked well together? And by that I mean maybe two bits of what we did perhaps like em.. tapping while we were saying something or anything like that.

The writing and drawing.

Well you got to eh imagine things .. and you've got to write about what you imagined.

Em..... Wh..when we got to imagine stuff like our name in bold letters like if music and [I: Oh yes] and em... telling the group about what we imagined.

Well em.. you asked us to em imagine.. your name and em make it more bold, make it more brighter, add colour to it and like if you want add music and add some movement and then em... after that yeh asked us what we all em saw [I: Uh huh] and then I all I remember after that is just (child 5) telling us what she saw and us all bursting out laughing.

Child 2

Em... Well, em... Like you mean sort of like um tapping your should... em sorry se em soldiers (shoulders) ***em and em sort of going around the room and things.***

Child 3.

Tapping and closing your eyes and sayin' 'I could do it'.

I: Have I got them all. .. Are there any things that you think went well together? You know we did say two bits together or a couple of bits together?

The scale of one to tens an' the talkin'.

I: Right, so the scale and the talking went together. Yeah. i..in what way do you think that went together well?

Like you would talk aboot stuff an' then you'd say what like what yeh were talkin' aboot you'd say like on a scale of one to ten what you 'hink aboot it or any'hing.

I: .. And how was that helpful do you think?... What was good about them being together?

I'm not sure. It just helped me a lot mare so.

Child 4

The butterfly hug and the... drawing.

I: .. The butterfly hug and the drawing. What was good about putting them together?

Because that, when I do the but'erfly hug it helps me concentrate more** [I: Mmm mmm] **and the drawing helps me think what that I'm doing bet'er.

I: .. So which do you use first? The butterfly hug or the drawing.

Butterfly hug. I'd probably say 'I can do it'.

Child 5

I: ..... and explain to me a bit about the patting of,,on the shoulder. What you mean by that ?

Well you just tap on the shoulder and saying, sayin' about.. 'I can do this'.

Em.. 'I can do this' and 'I can change', definitely.

Master theme 3: Generalisation

Subordinate theme: Use of EMDR

Child 1

Well em... When I do the tapping on my sh..should..shoulders I em I say the words like you can do it and em cos I used you can do it when I was learning my lines (for a school play) ***and like stuff like I can change .. and em also tapping is.. on sh..shoulders can like em make me feel more relaxed and like sometimes when I can't go to sleep I use the tapping too.***

Well, I shut my eyes and em do the tapping and like my dad says you could do that and like just imagine you're drifting into a soft fluffy cloud .. and em it makes me more relaxed and like after a wee while.. sleeping.

Child 2

I: Yes. Good. Okay.... Have you used any of the things you've learned?

Yeah. Sort of in bed .. and things.
Em... Well I sort of do the tapping .. and thing. And like I'd discovered that it also helps when you're scared as well .. because eh like I was believed in ghosts and things [I: Uh huh] so like em.. like when I get scared I keep like imagining things in front of my eyes .. and like I sort of keep seeing sort of black figures like going through my bedroom door and things.

I wasn't terribly confident .. and** [I: Of course] **so ah.. Sort of that's sort of changed things a bit.

I: What have you used from what we've done ... in the group?

The tapping.

Child 3

I was doin' ma homework an' I was stuck .. ah an' em so I done that an' then I tried it an' ended up the right answer so.

Child 4

Em. When I probably done that but'erfly hug .. it probably made me feel bet'er.

Child 5

I: ... That was a bit about how, what you liked about the, the group but the next bit I wanted to ask you an..and I think you've begun to answer that a little bit is. Which parts did you find helpful?

Well, the 'I can change'... Every time.. I..I do it at night at points.. so ah can have a good dream and think about, and think about it tomorrow.

The pattin' on the shoulder was definitely [I: Was..] helpful ..because ah had a test coming up [I: Yes] and ah passed it.

Well you just tap on the shoulder and saying, sayin' about.. 'I can do this'.

Em.. One.. em walkin' around the room.

I: Uh huh. And how, how did the walking fit in with that?

Well. I just go' up and start walkin' we..what make me go back to sleep.

I: And then what happened when you went back to bed?

Ah just fall right to sleep.

Subordinate theme: Use of SFBT

Child 5

..... and ev.. the wee purple, the pink book you gave us av, I write some down and.. put a scale eh one to ten .. sometimes have five, sometimes have nine, sometimes have one.

I: .. So you used your little book for that?

Yeah.

I: Uh huh. And what kind of things do you write in it?

Well ah write about the day, what happened. It's more like a diary eh me. .. An' av, ah never knew it an' ah was finished an' ah had to start on a new book.

*I: ... And you use scaling in it. Mmm mmm [**Yeah**]. How does that work then? How do you do that...?*

Well, um... Instead of puttin' a big long line of one to ten, .. I put different stuff like hearts, stars .. kind of bit of make like... make up accessories, cosmet** [I: Uh huh]... **and jewellery like that.

I: Right. Okay.. And what kind of things might you'd scale what might you do it on?

Em.. Ah.. Sometimes ma like ma nerves .. ma happ.. When am happy, sad .. excited.

I: .. And tell me a wee bit more about that. Is that helpful do you think or not helpful to you?

Helpful.

I: Yeah. In what way... ?

So ah can, ah can record what I've been doin' since.. an' remember what ah did before an' ah can do it again .. to make me more happy.

Or if it was sad a'd try, I'd try an' do the opposite of it.

Subordinate theme: Future Template

Child 1

I: ...So my next question is what have you learned from the group work that will help you in the future?

Well, em. To be confident and em be yourself and don't worry about things.

I: .. So be confident, be yourself and don't worry about things. Uh huh. Yeah. Anything else that you think will help you in the future?

The tapping.

I: The tapping. Okay. So how will that help you do you think in the future to be confident and not worry so much about things. How do you think that might help you in the future?

Well, em. In university and in high school when I'm doing my exams cos I want to be teacher and you'll have to get good qualifications .. and

so like just to be confident and not to worry about when you're doing them.

I: .. So it could have a big difference to you in your life in the future then.

Yeah.

Child 2

Eh.... Well, em... sort of, em..... like I can be confident at things [I: Uh huh] like so.. em I'm not going to be like as em.. less confident like in the future [I: Right]. Em..

I: You're not going to be as less confident. So y..you're going to be more confident do you think?

Yeah...em...like em I don't really have to worry em about.. em sort of.. em.. being confident at.. at sort of doing my work like getting wrong answers and things like that.

Child 3

To believe in yourself.

I: .. To believe in yourself. Okay. And what does that mean to you? What does it mean to believe in yourself?

Eh, like.. To... like not to doubt yourself like to say that you can day some'hing an' then try.

Eh. Not to get down on yourself an' just to try wey yeh want to dae.

Child 4

That even though if you're child.. . I'll probably tell my children when they're going eh school teh always be confident and brave.

I: Mmm mmm. And how will that help them do you think?

That will probably help them a lot.

I: Right. Because?

Because if they said I'm stuck and then they'll remember their mum saying just be confident and then they'll just be confident .. and get their work done.

Child 5

And probably about the ah think..the end of this year I'll probably need to ...' can change'. 'I can change... do more than like in young adult than...than ma usual self.

Em.. em... At the, at high school I'll try an' set some targets for me. Like targets to bring everything what ah need for ma class. Well the future I think 'I can do this' will be good for exams.

Master theme 4: Locus of Control

(My words are in parenthesis as a means of summarizing my interpretation of what the child appeared to be portraying)

Subordinate theme: Human Agency/Power

(I feel more relaxed)

Child 1

When I do the tapping on my sh..should..shoulders I em I say the words like 'you can do it' and em cos I used 'you can do it' when I was learning my lines and like stuff like 'I can change' .. and em also tapping is.. on sh..shoulders can like em make me feel more relaxed and like sometimes when I can't go to sleep I use the tapping too.

(It's like someone with me, someone beside me)

Child 2

Em... Well I sort of do the tapping .. and thing. And like I'd discovered that it also helps when you're scared as well.

The tapping — Em... Sort of.. it like acts.. like sort of.. em.. sort of someone like with me, beside me and things.

Um.... Well I was never the most confident person in the world. Em.. So it sort of boosted my confident a bit..

Em.. That like things aren't like em impossible to do sometimes so.

(Confident and relying on one's own power)

Child1

Well, em... The past couple of times when I've not really been confident about something I've done it cos em I'll, I was a wee bit scared today because I was the first narrator to stand up and introduce the play and em at home when I was learning my lines I was tapping my shoulders and t..today I didn't get a line wrong.

I: .... And tell me about something else you learned from the group work?

Em, well... To stay confident and em... like just be yourself.

Subordinate theme: Self-efficacy

(I'm no good at written work and maths)

Child 3

Well I thought it was goin' to be stuff like assessments and every'hing but...

I: Ah yes, but it wasn't was it? So you, you were expecting it to be something?

Hard.

Cos it (the group-work) ***can help yeh in loads of different ways like help you wey your school work and every'hing.***

Well. When I first came I wasnay that good at Maths even if my ma maths... and then when I started goin' I can do my maths in like at least about twenty minutes now but if it's like two pages so.

(I'm just naturally slow at doing work)

Child 2

Not really because like em... on like em... like... I like, I only really have one proper friend .. like in the class and like eh... he's sort of always the fastest to get finished [I: Right. Okay] em like with all the correct answers and things. Sort of he's always got his head down .. and like I'm usually like one of the last because like em like according to like teachers and 'hings I'm just naturally slow at doing work and things so.

Em... Well I know that I can do things .. like if.. like em I actually try so.

(I have Dyslexia)

Child 5

Ah like.. (coughs) ***I liked it (the group-work) because it was so cool .. em people were quite asking me questions where we've been all this.. sometimes.***

I: Asking you questions?

Yeah. Where we've been every Wednesday.

I: Oh. Were they?

Yeah . But ah couldn't tell them [I: Right. Just in..] Just in case. They think am goin'.. Ah think they think am kinda need some help.

Well I 'hink it's difficult to think about stuff .. because co.. of my dy'lexic cos I am half dy'lexic so .. kind of bit hard to remember words. Words an' memories.

An' the words are kind of bit easy but I'll forget them about.. three or six months.

Cos am, cos am dyslexic ah can't remem.. ah can't even say stuff like pineapple or that.

If something.. like. A person says something like pineapple ah can remember it.. on the other side of my brain .. bu', bu' in a couple of years time I'll forget about it.

(I believe in myself)

Child 5

(my teacher) ***She'll see higher standards .. of my work*** *[I: Right]* ***and my maths cos I'm really good at ma maths. .. And .. Ma spellin' is comin' on. Am gettin' everything right .. on ma spellin' test...***

Child 3

I: Tell me something that you learned from the group work?

To believe in yourself.

I: Uh huh. To believe in yourself. Okay. And what does that mean to you? What does it mean to believe in yourself?

Eh, like.. To... like not to doubt yourself like to say that you can day some'hing an' then try.

Subordinate theme: Effect

(I can learn)

Child 4

I: .. So was, was there anything helpful in what we did in the groups that helped you with that do you think?

Well I think it was drawing a picture of me, of me winning a prize.

For being the best .. speller and the, and the math, maths answerer in the world ... well but... when I learned after the group finished that I'm learning a lit'le more about things than I didn't before.

That, that, that I'm catching up with my times table .. because I'm up learning a lit'le of the times table I don't really know.

I learned that if you keep thinking abou' it and then if you come up with an answer just (put) the answer in. Even if you get it wrong it doesn't mat'er but you can try again another time.

Like if I got an answer wrong and I keep doing it and then I think of the answer a..again and again and then I get it right at the last time.

That, that even if, in my maths ev..even though if you're going on to a game and you get it wrong, you can always start again.

I'd tell them (my children) ***if you go*** (to school)... ***probably you'll learn more things to make you more confident.***

I: .. Anything else you might tell them?

And if, and if you're really stuck on your maths or spelling that they could probably help you think of a new way to do it without you noticing -like you're doing it.

(I don't go to learning support any more)

Child 5

An' am gettin' all my answers right an' ma shapes an' a got.. an' a passed ma, ma level.. B so ah got to a level C. (5 to 14 curriculum assessment levels)

Cos before ah was kind, ah didn't really like school that much .. so... I.. ah didn't have ma.. Ah didn't pass ma levels.

An'.. An' ah didn't study that, as much so ah went to em... learning support.

(Tapping helps me relax and concentrate)

Child 1

Well, when we went around in the circle if em and said our words it made me feel more relaxed and .. helped me and like concentrate a wee bit more too.

Well em... When I do the tapping on my sh..should..shoulders I em I say the words like 'you can do I' and em cos I used 'you can do it' when I was learning my lines (for a school play) ***and like stuff like 'I can change' .. and em also tapping is.. on sh..shoulders can like em make me feel more relaxed and like sometimes when I can't go to sleep I use the tapping too.***

Well, em... The past couple of times when I've not really been confident about something I've done it (tapping) ***cos em I'll, I was a wee bit scared today because I was the first narrator to stand up and introduce the play and em at home when I was learning my lines I was tapping my shoulders and t..today I didn't get a line wrong.***

Master theme 5: Relationships

Subordinate theme: Family support

Child 2

..like at home.. like I tend to be okay because like ah.. like I'm not, don't like have to do things that I'm not as confident at and things.

Well, I shut my eyes and em do the tapping and like my dad says you could do that and like just imagine you're drifting into a soft fluffy cloud *[I: Right]* ***and em it makes me more relaxed and like after a wee while.. sleeping.***

Child 1

I: .. So you've used that and you found it helpful then. Yeah? And it sounds like you told your dad about it as well. Yeah. What did you say to your dad or your mum about it...

Well, I told them both on the day when em I came back from the first session. Well everyday when I came back from the sessions I've told them what I've learned and what we've done.

Child 3

I: What if there was a film camera in your house? What might your family see now that's different?

***Nothing** (laughs)*

I: Nothing? Okay.

Apart fay my room's no always like a total tip just like a wee bit ...so I tidy it a lot mare now so.

Subordinate theme: Group support

I: So what I'd like to ask you now is. If you had been on you own doing all this work that we did together instead of in a group with other children. How would that have been different do you think for you?

(I'm not the only one with problems)

Child 2

Like em... It's like easier like to say like what you want whether it's like in a group there's lots of people who need to em say and things so.

Sort of like em.. like when other people say something .. eh.. like.. em... If they're not confident on something you like em realise that you're not the only one who's not confident .. you see so.

(I've made friends)

Child 1

Oh..... I wouldn't like get teh make friends and em wouldn't get teh like talk to them and learn what they like and like em.... see what they are inside and I didn't know that.

Em... When we... em stood up in the line and people were tapping the back of our shoulders and I was surprised that cos em I was a wee bit nervous about coming to this group .. but then em when I met the people and started to know them like I've made more friends from them (the children who attended the group).

Well em... (child 5) and.. (child 5) is just like somebody before the group I would just like say hi to when I was passing but sometimes I'll play games with (child 5) and D (boy who was not in the group).

(I enjoyed it)

Child 5

I: No. Right. Okay. So what else might you tell another boy or girl who might be thinking about (coughs) *going to a group like that?*

.. say you have a really good time.

And you do really cool stuff.

Em... They get too... think about stuff like.. certificate things, like being really happy .. and.. being... doin' like really fun things like drawin' pictures about it .. and some other people write stuff about you.

I: So on a..a scale of one to ten now that you've finished the group. Remember you said at the beginning (before you came to the group) "I was kind of a bit of a five. I wasn't very sure." Where would you put yourself now about how much you liked being in the groups eh if one is not very much and ten is I really loved being in the groups?

Child 1

Ten.

(Others can help me)

Child 3

Well you dunnay feel on your ain or any'hing you just have like loads of people that can... like see if your stuck of some'hing like how to spell some'hing they can help yeh or some'hing like that.

Like they can help yeh and that.

Child 4

It was better to have people in my group.

I: .. Why was it better? What was better about having other people with you?

Because it likened telling you more things how you could get be better at your work. Like, like if you.. Like if you fe.. felt a lit'le worried about you cann't do it. They can just tell you that you could do it. Just .. keep thinking abou' it.

I might *[I: Now]* ***be doing.. other things that people wi..would be doing.***

I: .. Like?

Like..... Like probably.. being... Like probably learning new things.

(I'm included and blending in)

Child 1

I: What did you like about the group work?

Eh, em... Just like em being in the whole group.

Child 5

Well. Ah feel like it would be like left out and *[I: Mmm mmm]* ***an' feel kind of bit stupid like with all the rest of the people*** *[I: Uh huh]* ***an' feel a bit, kind of bit different.***

I think it would be better to keep.. like to go into groups.

I: .. Because?

Because it.. you feel, you feel like you're blending in with the other people.. and havin' conversations with them.

Well ah.. A'd rather be in a group because it would.. build up ma... my group skill cos am not very good with people...

Child 1

I: ... What did you like about the group work?

Eh, em... Just like em being in the whole group

Well em.. you asked us to em imagine.. your name and em make it more bold, make it more brighter, add colour to it and like if you want add music and add some movement and then em... after that yeh asked us what we all em saw .. and then I all I remember after that is just (child 5) telling us what she saw and us all bursting out laughing.

I: .. Anything else you want to ask or tell me?

Em.. Em... To tell you that I really enjoyed this group.

Child 2

Like em... It's like easier like to say like what you want whether it's like in a group there's lots of people who need to em say and things so.

I: Yeah. Wh..what kind of things do you think wo..would be easier to say? What do you mean by that? Can you give me an examp....

Sort of like em.. like when other people say something .. eh.. like.. em... If they're not confident on something you like em realise that you're not the only one who's not confident .. you see so.

Child 3

It would nay be that good because it would nay really be.. all like.. a lot mare stuff like that you could do with everybody else. .. Like writin' aboot each other an' stuff.

Well you dunnay feel on your ain or any'hing you just have like loads of people that can... like see if your stuck of some'hing like how to spell some'hing they can help yeh or some'hing like that.

Like they can help yeh and that.

I: .. Which particular parts of the work made you think about this differently do you think?

Em... Probably the bit where we were up around the room and every'hing.

I: Where we were walk...

Like eh runnin' around the room.

I: .. How do you think that made you feel differently? What was different there...

Cos you didn't like you had each other, you're tapping each other shooders an' then you didnay like yeh, yeh didnay have to say any'hing you just had to hink aboot what you had done, wha, what you could do an' every'hing so.

Child 4

It was better to have people in my group.

Because it likened telling you more things how you could get be better at your work.

Like, like if you.. Like if you fe.. felt a lit'le worried about you cann't do it. They can just tell you that you could do it. Just.. keep thinking abou' it.

Child 5

Well. Ah feel like it would be like left out and *[I: Mmm mmm]* ***an' feel kind of bit stupid like with all the rest of the people*** *[I: Uh huh]* ***an' feel a bit, kind of bit different.***

I think it would be better to keep.. like to go into groups.

Because it.. you feel, you feel like you're blending in with the other people *[I: Right]* ***and havin' conversations with them.***

I: ... And any other reasons you can think of that's better to be with other children rather than doing this work on your own?

Well ah.. A'd rather be in a group because it would.. build up ma... my group skill cos am not very good with people *[I: Mmm mmm]..* ***but ah have tons, now ah have tons eh friends ....***

Subordinate theme: Friendship

Child 5

Now I've got tons of.. got lo.. tons of friends, about ten of them, ten or eleven. Boys and girls.

... ah have tons, now ah have tons eh friends .. and we all have a, we have a gang an' all that [I: Right. Okay]. More and more people come, are comin' in .... our new girl,she's, she's American .. am goin' eh her house .. today or tomorrow. I can't mind.

Child 1

like them cos I've been swapped into different class cos all the classes got em shuffled about and I got people from different classes in my class. So like I've made friends with new people and .. she would've saw that I've em made quite a lot of new friends.

And that em I've made.. I'm like.. I've got em... Well I've made more friends on my street which I haven't known before like when they're just outside go up to them and em get them they would see that I think. Cos my new friends have been in my house too.

Em... When we... em stood up in the line and people were tapping the back of our shoulders and I was surprised that cos em I was a wee bit nervous about coming to this group .. but then em when I met the people and started to know them like I've made more friends from them (the children who attended the group).

Child 2

... like... I like, I only really have one proper friend .. like in the class and like eh... he's sort of always the fastest to get finished .. em like with all the correct answers and things.

Master theme 6: Feelings

Subordinate theme: Happiness

Child 1

Well em... When I do the tapping on my sh..should..shoulders I em I say the words like you can do it and em cos I used you can do it when I was learning my lines and like stuff like I can change .. and em also tapping is.. on sh..shoulders can like em make me feel more relaxed and like sometimes when I can't go to sleep I use the tapping too.

Well, it just makes me feel em happy .. that I've got quite a lot of friends and em I can be a friend and be more confident.

Child 3

I: It was your style. That's right, yes. Uh huh. And did you know that before about yourself?

No, not really.

I: Right, so it was something new then. Yeah. Okay. How did you feel about that?

Happy.

I: Right. What, what, what made you feel happy do you think?

That somebody said that I had like... good style in clothes and every'hing.

Child 5

Well the... for being happy ss, for the trophy or the certificate.

....and ev.. the wee purple, the pink book you gave us av, I write some down and.. put a scale eh one to ten *[I: Right].* ***Sometimes have five, sometimes have nine, sometimes have one.***

I: ...And what kind of things might you scale? What might you do it on?

Em.. Ah.. Sometimes ma like ma nerves .. ma happ.. When am happy, sad .. excited.

I: .. And tell me a wee bit more about that. Is that helpful do you think or not helpful to you?

Helpful.

I: Yeah. In what way?

So ah can, ah can record what I've been doin' since *[I: Uh huh]* ***an' remember what ah did before an' ah can do it again*** *[I: Right]* ***to make me more happy.***

Or if it was sad a'd try, I'd try an' do the opposite of it.

(My teacher will be happy)

Child 4

(sighs) ***If she*** (my teacher), ***if she probably realise that I'm learning more than I used to like day dreaming .. and, and now I'm not day dreaming I'm just concentratin'. She'll probably be happier.***

Child 5

She'll see higher standards .. of my work .. and my maths cos I'm really good at ma maths ... And.. Ma spellin' is comin' on. Am gettin' everything right *[I: Right]* ***on ma spellin' test. And .. am probably about... in.. and the, the smile on ma face at points. The teacher know ah have a smile on ma face ah had a good time or something.***

Subordinate theme: Laughter

Child 4

I liked it when we, when we went around in a circle tapping each others' shoulder.

I: Oh yes. Uh huh. Yeah. What was good about that?

Because it made me laugh a lot.

Child 1

Well em.. you asked us to em imagine.. your name and em make it more bold, make it more brighter, add colour to it and like if you want add music and add some movement and then em... after that yeh asked us what we all em saw *[I: Uh huh]* ***and then I all I remember after that is just (child 5) telling us what she saw and us all bursting out laughing.***

I: So if there was a video camera in your classroom making a film of you now what might Miss – (your teacher) see in the film that was different from before you started coming to the group?

Well, em. Having a laugh with Miss - and em talking to her about .. things.

Subordinate theme: Empathy

In school

Child 1

Well, em.. What I liked about the guessing was in that.. cos like.. it's like ee em you don't really know the person but once you've wrote down what you think they're good at and you ask them if they're good at that you like, you can em you know that they're going to be good at like if. For child 3, cos I had to do him em and eh cos he mentioned em PS 2 that I would write down PS 2 and he's quite good at the play station.

..... and in the playground sometimes cos I see(child 4) alone I'll feel sorry for her and ask her if she wants to come and play.

Well, em..... Just like.. just for you em.. em I'm not sure if this is the vocabulary to use it but em .. you're considerate about other people.

I: ...if you had been on your own doing this work instead of with other children in a group how would that have been different?

Oh..... I wouldn't like get teh make friends and em wouldn't get teh like talk to them and learn what they like and like em.... see what they are inside and I didn't know that.

Well, em... Like the saying you can't judge a book by it's cover. You can't judge a person on what they look like and like it's what's underneath counts and they're all quite nice.

Child 4

(sighs) ***If she*** (my teacher), ***if she probably realise that I'm learning more than I used to like day dreaming*** *[I: Mmm mmm]* ***and, and now I'm not day dreaming I'm just concentratin'. She'll probably be happier.***

At home

Child 1

That I've em... started to care quite a lot about my big brother and I've started to em care about the rest of my family too. I would praise my brother for eating em stuff. He would see that I've started to care for him more and the like I'm considerate about him.

(I benefited and so could my friends)

Child 5

.... ***Well I would recommend, recommend this to A or D*** (girls who were not in the group). ***They're... well o' course I'm kind of dyslexic*** *[I: Mmm mmm]* ***so.. they're kind .. they're, they're kind of bit too so.***

Em... They get to... think about stuff like.. certificate things, like being really happy .. and.. being... doin' like really fun things like drawin' pictures about it .. and some other people write stuff about you.

Well... we... we talked a little bit more about it *[I: Mmm mmm]* ***and we can help some people .. For example, ah helped them.. ah said tey (child 4) she was a good drawer .. and... (child 1) said ah was a.. ah was givin' him good advice.. after .. after we went, went out.***

I: Oh right. Okay. So, so after the group then (child 1) *was talking to you about it.*

(Awareness of self/self absorption)

Child 4

Like I used to play tig and hide and seek but now I'm not I'm just walking about.

I: .. And what's different about that?

... ***Cos if I run about I.. because I have a problem with my lungs cos I've got the asthma.***

Appendix 18: C***omparisons of comments made by teachers and parents pre the intervention***

Pre intervention	***Teacher***	***Parent***
Child 1	Needs reassurance Looks worried Bit of a hypochondriac, especially when work starts Scared of he fire alarm	Restless Worries, afraid of new situations Aches and pains Shouts, bangs doors and swears Doesn't cope well with changes
Child 2	Unsure of himself Not very happy Few friends Twitches Difficulty expressing feelings	Fearful of new situations Aches and pains Solitary Twitches
Child 3	Doesn't show much emotion Responses often limited Occasionally initiates contact with another child Worries	Cries easily Bit fearful of new situations
Child 4	Withdrawn Almost never says anything Usually alone Hardly ever curious Unsure of herself Needs reassurance Appears miserable	Stares into space Cries easily Short attention span Give up easily

Appendix 18

Child 5	Very quiet Can't stand up for herself Hardly ever names feelings Almost never has a friend of her age Plays with younger children Seeks help without trying first	Tearful Destroys things Has refused to go to school Stays in her bedroom Gives up easily Not liked much by other children Aches and pains Bites her nails

Appendix 19: ***Comparisons of comments made by teachers and parents post the intervention***

Post intervention	*Teacher*	*Parent*
Child 1	Not needing reassurance More at ease Smiles more No longer scared when fire alarm rings Appears calmer Volunteered to be the team leader Generally mixes well now	"Last summer children and their parents didn't want him to play. Now he has people to play with." More confident Able to converse more Has friends now Still gets angry but more self-control and calms down quicker. No swearing recently. Less restless Not afraid of the fire alarm now Less aches and pains
Child 2	Becoming more confident It seems to have given him the language to express how he is feeling	"This little programme has helped him a lot." Less worried Saying how he feels Now has a couple of friends No twitches for months Took part in activities that he wouldn't in the past
Child 3	"The change came about rapidly" Has a smile on his face Popular with the girls Has come out of his shell	Room tidier Does homework

Appendix 19

	More sociable Will now ask for help or clarification Homework always done now People now choose him as a partner	
Child 4	"At camp she was full of enthusiasm and tried abseiling - for her it's like attempting Mount Everest." Working now Will try more things, e.g. writing Won a prize for the child who made the most effort Will now initiate conversations Volunteers to give out the jotters Does her work and accepts guidance Writing in whole sentences now Trying really hard and keeping up with her group	***Not able to contact parent***
Child 5	A bit more assertive now Confident in herself Will speak up and more likely to volunteer answers Has friends of her own age now More confident academically Has made great strides in personal development	"I'm that pleased with her, the change is immense. It was breaking my heart to see her unhappy." Changed totally Much more confident Friends call to the house for her Hardly ever in now Loves books now and helped her sister with reading for the first time She is speaking up for herself – she has an opinion and wants to be heard

Appendix 20: ***Comparison of comments from teachers pre and post intervention***

Teacher	*Pre intervention*	*Post intervention*
Child 1	Needs reassurance Looks worried Bit of a hypochondriac, especially when work starts Scared of he fire alarm	Not needing reassurance More at ease Smiles more No longer scared when fire alarm rings Appears calmer Volunteered to be the team leader Generally mixes well now
Child 2	Unsure of himself Not very happy Few friends Twitches Difficulty expressing feelings	Becoming more confident It seems to have given him the language to express how he is feeling
Child 3	Doesn't show much emotion Responses often limited Occasionally initiates contact with another child Worries	"The change came about rapidly" Has a smile on his face Popular with the girls Has come out of his shell More sociable Will now ask for help or clarification Homework always done now People now choose him as a partner

Appendix 20

Child 4	Withdrawn Almost never says anything Usually alone Hardly ever curious Unsure of herself Needs reassurance Appears miserable	"At camp she was full of enthusiasm and tried abseiling - for her it's like attempting Mount Everest." Working now Will try more things, e.g. writing Won a prize for the child who made the most effort Will now initiate conversations Volunteers to give out the jotters Does her work and accepts guidance Writing in whole sentences now Trying really hard and keeping up with her group
Child 5	Very quiet Can't stand up for herself Hardly ever names feelings Almost never has a friend of her age Plays with younger children Seeks help without trying first	A bit more assertive now Confident in her own abilities Will speak up and more likely to volunteer answers Has friends of her own age now More confident academically Has made great strides in personal development

Appendix 21: ***Comparison of comments from parents pre and post the intervention***

Parent	*Pre intervention*	*Post intervention*
Child 1	Restless Worries, afraid of new situations Aches and pains Shouts, bangs doors and swears Doesn't cope well with changes	"Last summer children and their parents didn't want him to play. Now he has people to play with." Less aches and pains More confident Able to converse more Has friends now Still gets angry but more self-control and calms down quicker No swearing recently. Less restless Not afraid of the fire alarm now
Child 2	Fearful of new situations Aches and pains Solitary Twitches	"This little programme has helped him a lot." Less worried Now has a couple of friends No twitches for months Took part in activities that he wouldn't in the past Saying how he feels
Child 3	Cries easily Bit fearful of new situations	Room tidier Does homework

Appendix 21

Child 4	Stares into space Cries easily Short attention span Gives up easily	Not able to contact parent
Child 5	Tearful Destroys things Has refused to go to school Stays in her bedroom Gives up easily Not liked much by other children Aches and pains Bites her nails	"I'm that pleased with her, the change is immense. It was breaking my heart to see her unhappy." Changed totally Much more confident Friends call to the house for her Hardly ever in now Loves books now and helped her sister with reading for the first time She is speaking up for herself – she has an opinion and wants to be heard

Final comments made at closure meeting with children on 18.05.05.

Child 1. My spelling is good.
I use tapping and the butterfly hug.
I use 'I can change'.

Child 2. Spelling and maths have improved (I use a calculator)
I use the butterfly hug taps at swimming (for diving in).
I use tapping.

Child 3. I am better at maths.
I use tapping.

Child 4. I got a certificate in school for being the star writer – my handwriting is good now.

Child 5. I buddy the little ones in school.
I have loads of friends now and no arguments.
I use the butterfly hug and the words 'I can change'.
"See being here – it feels like my world is falling into place"
(Comment made by child 5 spontaneously while drawing her picture).